DOCUMENT RESUME

ED 144 339 EC 102 467

AUTHOR Ten Broeck, Elsa
TITLE Extended Family Center 1972-1975. Final Report.
INSTITUTION Mission Neighborhood Center, Inc., San Francisco, Calif.
SPONS AGENCY Office of Child Development (DHEW), Washington, D.C.
PUB DATE 75
GRANT OCD-CB-366
NOTE 76p.

EDRS PRICE MF-$0.83 HC-$4.67 Plus Postage.
DESCRIPTORS *Child Abuse; *Day Care Programs; Demonstration Projects; Early Childhood Education; Family Counseling; *Family Day Care; Infancy; Neglected Children; Parent Counseling; *Program Descriptions; Program Evaluation
IDENTIFIERS Final Reports

ABSTRACT

Presented is the final report of a 3-year project to provide treatment in a community day care setting for abusive parents and their children. Project activities are reported for each year, and specific issues are raised. The first year is explained to have included a planning phase and pilot program, with primary emphasis on developing a theoretical model in which the parents' needs for dependency and trust were stressed. Described are second year activities which focused on expanding the program for the children (including such services as an infant and preschool program and individual rehabilitation) as well as the parents (including occupational therapy and group counseling). Administrative issues are said to have been a major concern during the project's third year. Conclusions are provided for each of four program components: parent services, children services, center services and staff services. Noted in a discussion of project impact is the replication by other communities of a family center with day care and parent services. Among four appendixes is a job questionnaire used for staff selection. (CL)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED144339

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

FINAL REPORT
EXTENDED FAMILY CENTER
1972 - 1975
GRANT #OCD-CB-366

Submitted By: The Staff of the Extended Family Center 1972-1975

Joan Becker - Head Teacher
Diane Bieber - Teacher
Castro - Social Worker
...cupational Therapist
...ina Davis - Teacher
Denise Escontrias - Secretary
Richard Escontrias - Teacher
Sharon Fee - Parent Consultant
Corinne Furgoni - Occupational Therapist
Peggy Hall - Parent Consultant
Roy Hamilton - Teacher
Wallace Johnson - Social Worker
Susana Raine - Head Social Worker
Peter Rivera - Teacher
Steve Stripp - Associate Director
Elsa Ten Broeck - Director
Hector Torres - Social Worker
Roxkanda Torres - Administrative Assistant
Letisha Wadsworth - Head Teacher
Dan Webb - Assistant Administrator

EC102467

FOREWORD

This report is submitted to the Office of Child Development in fulfillment of the requirement for research and demonstration grants. It is also written to communicate the ideas and experiences gained from an intensive effort to deal with the problem of child abuse.

The work at EFC was contributed to by numerous agencies and individuals. I wish to give particular recognition to the following persons whose efforts contributed in no small way to the work discussed in the following pages:

Kathy Armstrong, Berkeley Planning Associates
Glen Brooks, Former Director, Mission Child Care Consortium
Susan Castro, Former Director, Mission Child Care Consortium
Anne Cohn, Berkeley Planning Associates
Fred Collignon, Berkeley Planning Associates
Bess Davoren, Consultant
Dr. Moses Grossman, San Francisco General Hospital
Marcia Kallan, Consultant
Linda Kinrade, Nurse Practitioner
Ed Nathan, Zellerbach Family Fund
Dr. Delmar Pascoe, San Francisco General Hospital
Jorge Santis, Former Social Service Coordinator, Mission Child Care Consortium
Cecilia Sudia, Office of Child Development

This report covers the three years that EFC was a demonstration project. It does not discuss the work done by the Center during its final year of operation (1975-1976). The report reflects the work of the entire staff but was written by and from the perspective of the director.

In submitting the report I wish to make final acknowledgement to the children and parents of EFC without whom this report could not have been written. The following pages reflect the experiences that the families were willing to share so that information could be gained that would help others like themselves. I am indebted to them for their patience and their honesty.

Elsa Ten Broeck

Elsa Ten Broeck
Director, Extended Family Center
1972-1975

TABLE OF CONTENTS

Page

History 1

Program Overview 5

Year I--August, 1972 - June, 1973

Planning Phase (August, 1972 - January, 1973) 5

Activities 5

Issues 6

Pilot Program (February - June, 1973) 8

Activities 8

Issues--Parents 10

Issues--Children 11

Issues--Agency 13

Year II--July, 1973 - June, 1974

Activities 13

Issues--Administration 15

Issues--Parents 17

Issues--Children 19

Year III--July, 1974 - June, 1975

Activities 21

Issues--Staff 23

Issues--Administration 24

Issues--Parents 25

Issues--Children 29

Page

Program Components: Conclusions. 31

Parent Services. 31

Occupational Therapy. 32

Casework Services 33

Group Therapy 33

Children Services. 34

Center Services. 35

Staff Services 36

Staff Selection 37

Staff Training. 38

Staff Management. 38

Final Conclusion: "Did It Make Any Difference?". 40

Appendix 1—Description of Parent Consultants

Appendix 2—Job Questionnaire Used for Staff Selection

Appendix 3—The Retreat and the Return: Symptoms and Responses to Therapeutic Treatment of Physically Abused Children

Appendix 4--Report of EFC Closure Published in S.F. Child Abuse Council Newsletter

HISTORY

In December, 1971, Susan Castro, executive director of the Mission Child Care Consortium, a non-profit corporation supported by Model Cities funds, called a meeting of professionals in San Francisco involved in treating child abuse. At that time the Consortium was planning its second year action budget and was interested in expanding its current program of work-related day care into day care services that could meet the needs of "special children." The Consortium served the Mission Model Neighborhood District of San Francisco and became alerted to the particular needs of abused children through work being done at S.F. General Hospital also located in the Mission District. As a result of that meeting, the Consortium received support from local agencies dealing with abused children to draft a proposal for family services that would provide day care services to children as its central focus. The agencies represented agreed that such a service would supplement rather than duplicate existing services, which were extremely limited.

Elsa Ten Broeck, a social worker who had worked in Protective Services and on a special project for abused children at S.F. General Hospital, drafted the service component of the proposal. The Consortium staff worked on the organizational framework and funding resources. The service proposal was discussed with local agencies who served abused children (Juvenile Court, Protective Services, local hospitals) and commitments to refer families were obtained. The original proposal was submitted to the Office of Child Development (OCD) in March, 1972, for funding as a Research and Demonstration grant with a 10% local match for federal funds to be provided by the Mission Child Care Consortium out of its Model City budget. The Consortium also obtained endorsement of this project from the Model Cities community through approval by the Consortium Board of Directors and the Board of Directors of the Mission Model Neighborhood Cooperation (overseers of the Model Cities funds).

The original proposal submitted by the Consortium envisioned a Center offering parent and children services to 25 families including day care to children ages 0-10 years, group and individual therapy for parents, and 24-hour emergency services to the total family. Services were to be offered to both preventive and identified cases of child abuse referred from within the Mission Model Neighborhood. Geographic limits were required by the use of Model City

funds as match money. In May, 1972, Mr. Castro was contacted by Cecilia Sudia, project manager of OCD, who expressed interest in funding the project if the Consortium was willing to change its original application to meet OCD concerns. Funding of a three-year research and demonstration grant was awarded to the Consortium in June, 1972, with the understanding that the Consortium during the first year of the project would conduct a six-month planning project and a six-month pilot program for ten families and not begin full operation of a Center for 25 families until fiscal year 1973-1974. This change was made to develop a more refined program based on demonstrated needs from the pilot program.

It is important to highlight at the beginning of this report some of the political realities facing the Consortium at the time that it established the Extended Family Center because many of these realities greatly affected the process and outcome of the work done at the Center. The MCCC was one of seven corporations established by a Model Cities contract with the City and County of San Francisco. These corporations were set up in a low income disadvantaged neighborhood (the Mission District) to provide services and jobs for residents of that neighborhood. Although the Mission District is composed of a range of ethnic groups, the political force that obtained Model Cities funding was dominated by the Spanish-speaking population which is centered in the Mission District. Politically, the Model Cities program was planned as a program to meet the needs of the Spanish-speaking population in San Francisco. The Consortium was unique within the Model Cities Corporations because its service, day care, allowed it to utilize Model Cities funding to generate additional funding such as Title IVA and the OCD grant. As a result it developed a number of contracts with funding agencies that had expectations of services which often differed from the Model Cities expectations. At the same time, the Consortium's primary identity remained as a Model Cities program bound by the rules of providing services to and employment for neighborhood residents.

The OCD contract for EFC is a prime example of the conflict in funding expectations that the Consortium generated by expanding its services. Theoretically, EFC was to be an extension of the Consortium's service to the Mission District through the provision of specialized day care services to children who had unique needs. The Center would also offer employment to residents of the District who were qualified to care for children but were not employed in regular programs because of academic and/or language barriers.

In reality, EFC could not meet either expectation. Child abuse in Spanish-speaking families was underreported. There was resistance within the Spanish-speaking community toward developing a Mission District child abuse center because it was believed that the Center might reflect negatively upon the child-rearing practices of the Spanish-speaking population. In addition, services for abused children throughout the city were so limited that there was tremendous pressure among professionals in the field to make the demonstration services available to all abused children in San Francisco. Potential referral services in the general community were staffed by a multi-disciplinary group of professionals who made it clear that unless professional staff were available at the Center they would not refer clients and the program would not succeed. Because OCD required referrals from these agencies, the Consortium was faced with a direct conflict over its policy of hiring only neighborhood residents.

The Consortium's work-related day care program consisted of 5 day care centers administered by a central office. Although the staffs were multi-racial, the administrative positions (director, head teachers, social workers, administrative assistant) were all held by Spanish surname, bi-lingual Anglos, or Anglos who were involved in the political organization that obtained the Model Cities funding. An exception in this policy was made when the director of EFC was hired. In order to reassure OCD and the professional community, a white non-Spanish-speaking MSW (who did not live in the District) was hired. In addition, the Board of Directors delegated policy decisions about EFC to the executive director of the Consortium. EFC was also unique from the other day care centers in the Consortium because the executive director delegated administrative responsibilities (both programmatic and fiscal) to the Center director. As a result, EFC operated almost autonomously by maintaining its own books, setting up its own personnel policies and making policy as well as administrative decisions in isolation from the rest of the Consortium.

The primary reason for this type of administration was the political climate facing the Consortium at the time EFC began operations. Just as EFC was a "maverick" operation within the Consortium, the Consortium was regarded as "maverick" within the Model Cities Corporations. Within the first year of the Consortium's operations it was apparent that the purposes and orientation of the Consortium and the Model Cities Board were vastly different, and an open struggle for political and fiscal control quickly ensued. In November, 1972 (four months into the first year of the EFC contract), the Model Cities Board refused to sign the Consortium's second year contract and

We wanted a professional but certainly had no objections to their being residents or non-anglo. 8

held up all Consortium funding. The Consortium then operated on a continual crisis basis resulting in inordinate amounts of staff time being devoted to political activities necessary to ensure the survival of the program. The EFC program in contrast was well funded and utilized a low-profile political strategy which was supported by the Consortium administration through the continued delegation of all program and policy responsibilities to the EFC staff.

The complications of this history were that for two years EFC operated as an independent entity with few if any administrative constraints or supports. Decisions were made internally by Center staff which allowed for an initial flexibility and creativity both in program content and administrative style. However, this unique situation also created a great deal of strain on the Center director (who had to maintain a very cautious political position) and hampered the initial effectiveness of the project due to lacks in administrative support that are normally available through a sponsoring agency. The political climate also created an isolation of the Center that in the long run hampered its effectiveness to reach potential clients and to fulfill the Consortium's original goal of expanding its network of neighborhood services. In retrospect, one can see that without the isolation from the political crises of the Consortium the Center program as a demonstration model in child abuse would not have survived. However, the total delegation of responsibility for the Center by the Board of Directors of the Consortium was probably unnecessary and limited the effectiveness of the Center's overall program.

PROGRAM OVERVIEW

The purpose of this section is to give a perspective on the development of the Center by examining each year in terms of its major activities and the primary issues faced by the Center at that point in time.

YEAR 1--AUGUST, 1972 - JUNE, 1973

Planning Phase (August, 1972 - January, 1973) [At this time the Center was known as the Child and Family Project]

Activities: The planning phase was defined as an opportunity for the Center staff to plan in detail a pilot program that would test out the feasibility of providing treatment to abusive parents and children in a community-based day care program. The Consortium hired three staff to implement this period: Elsa Ten Broeck, a trained social worker experienced in the field of child abuse and neglect; Steve Stripp, a trained psychologist experienced in early childhood education and administration; and Rokanda Torres, a Spanish-speaking secretary experienced in working with Mission District residents. This staff completed the following tasks:

- Reviewed existing services and needs for services for abusive families both in the Mission District and in the city of San Francisco.
- Established an Advisory Board to the Center composed of representatives from referral agencies, community members, and abusive parents who would advise Center staff and administration on the Center programs. The Board was established to keep close coordination and communication between the Center and the established child abuse network in the city. It was also hoped that the Board would help ease tensions in the Mission District about the Center's existence and purpose.
- Developed and began to implement the pilot program. The initial staff served as the administrative staff responsible not only for writing the pilot program but for setting up from scratch all administrative details of the Center. Because of the uniqueness of the Center vis-a-vis the rest of the Consortium's program, its administrative framework had to be developed by the Center staff.

At the end of this period the staff submitted to OCD an initial report on the Pilot Program and its research design. The program proposed to serve ten families with an age limit on the identified child of 5 years. Families would be offered occupational therapy as well as group therapy along with individual counseling, advocacy services and 24-hour emergency services. Child abuse was defined as "the inability to protect a child from physical harm" and intake criteria accepted only cases where a physical injury had occurred. In addition to formal therapy, parent involvement in the program was set up through parent participation on a Parent Board and Community Meetings of Center staff and parents. The Parent Board and Community Meetings would be a time when issues about Center program, policies and staff could be discussed by everyone involved in the program. The Parent Board and Community Meetings were implemented as part of the Center's philosophy of consumer participation and as a means to meet the Consortium policy that all Centers in the Consortium develop mechanisms for parent input into the Center. Each Center in the Consortium also elected a parent as a voting member on the Consortium Board of Directors. During the planning phase of EFC the executive director of the Consortium approved the recommendation of the EFC director that EFC not elect a parent representative to the Board. This decision was made because the EFC parents attended the Center due to intervention in their life rather than by choice (as was the case in the other Centers of the Consortium) and because the EFC director felt that the political pressure put on the Consortium Board of Directors would be detrimental to the emotional well-being of the EFC representative. This decision is another indication of the conflict of purposes between EFC and the Consortium and created continued stress between the Board of Directors of the Consortium and the EFC staff. During the last year of the program, an EFC parent was elected to the Board and functioned to the benefit of the Board, EFC, and the parent himself.

Issues: The most important issue addressed internally during this period was the philosophy and model of treatment. The following statement was submitted to OCD as the philosophy of treatment in October, 1972, and remained throughout the three years.

> The Project's treatment philosophy is that battering parents are the persons best able to treat the child abuse syndrome. Our program will help parents recognize their ability to help other parents and therefore themselves. The program has built in parent participation in both the Day Care Center and the Treatment Program. The staff will serve as a means for parents to develop

and use that participation. The primary mode of treatment will be the use of group therapy. Parents will meet to discuss their problems and help each other reach an understanding of their behavior and alternatives that will create more optimal functioning. Individual treatment will be available but parents will not be viewed as "clients" needing professional care and therefore unable to treat others due to their own pathology.

At the end of the pilot program the Center stated a model of treatment which underwent significant changes during the second and third years of experience. It is quoted here to show how the Center began implementing the treatment philosophy; the changes in the implementation process are discussed under the Third Year Overview.

Theoretical Model

The Center's program is based on the philosophy that abusive parents are individuals who have been raised in a manner that thwarts their ability to nurture a child. Because abusive parents have not had their needs met nor have they been recognized as individuals of worth, they find it difficult and sometimes impossible to tolerate the demands and needs of young children. The child's demands are responded to with violence because the parent views the child as a miniature adult and imparts on him/her adult behavior and reasoning power. When a child does not behave as expected the parent feels justified in injuring the child believing that the child (no matter how young) is willfully misbehaving. This type of theoretical model requires treatment programs geared to meet dependency needs and to improve parental self-image. Our parents need to be encouraged to be dependent (something they were never allowed to be as children) so that they can become independent in a more positive manner. To develop the trust necessary to allow dependency, much of our initial services included concrete help such as rides home, help with shopping, a cup of coffee, going out to lunch, etc. As parents began to respond to staff concern and support, trust developed, and treatment could begin.

A second major issue faced during the Planning Phase was the inclusion of parents into the planning and operation of the Center. As noted above, the Consortium required parent participation in the operation of the program. In addition, the philosophy of the Center was to approach treatment from the position of respect for the parent's ability to solve his/her problems. The first step in implementing this philosophy was the hiring of two formerly abusive parents as consultants to the Center. (See Appendix 1 for descriptions of parent consultants.) During this phase, Ms. Hall and Ms. Fee participated in Advisory Board meetings and staff selection. Their involvement in EFC greatly influenced the direction of the entire program and in particular our commitment to parent involvement and parent control. What occurred during this part of

the Center's development and continued as an influence on the program was the reality gained by having direct input on an equal level from people who had experienced and endured what staff members could only assess and theorize: the experience of actually abusing a child. The success of the Parent Consultant program is the most significant reason why the original treatment philosophy was developed and remained intact throughout the three years.

A third significant issue faced during the Planning Phase was the criterion for staff selection. Again the political framework was an important factor in decisions that were made. Political pressures upon the Center staff and the Consortium at large were at their height during hiring for the pilot staff. All hiring had to be done through the Model Cities Hiring Hall with priority to be given to qualified local residents and with preference to Spanish-surname applicants. Final selection of the Head Teacher was made by a committee of parents from the Consortium including one of the Parent Consultants from the EFC Advisory Board to represent EFC parent interests. Equally concerned about the hiring was the professional child abuse community, who expressed concern about the quality of service and the need for trained staff. The internal priority set by the Center staff doing the hiring was finding staff that could best implement the type of program being proposed. Selection was made on the type of personality and ability to be trained rather than academic degrees and expertise. Internal criteria also included a priority for a staff that was representative both ethnically and ~~sexually~~. (See Appendix 2 for questionnaires used to select staff.)

Pilot Program (February - June, 1973)

Activities: The initial activity of this phase was renovating and creating a physical space for the Center. The Consortium obtained a site for the Center which included space for day care as well as a Parent Center and offices. The building was an old store front downstairs (used for the day care) and a flat upstairs. The staff had the opportunity (and chore) of creating their own space. The first month of the Center's official activities were spent working on the space as well as inservice training.

Specific decisions about how the staff would work together were left until the entire staff was hired and on the job. Job descriptions, assignments, and much of the program were reviewed by the entire staff during this period (and with great regularity throughout the three years of demonstration project)

and changed according to the needs of the staff and the program. During inservice training, the value and contributions of the Parent Consultants became so apparent that they were hired as part-time staff for the pilot project. Staff visited numerous agencies, and became familiar with the child abuse system as well as the theoretical issues in the field. In addition, training was offered around medical aspects of abuse, the exceptional child, culture, language, dialect, and child-rearing patterns of different ethnic groups.

After initial training, the staff began to recruit cases. Due to the geographic restrictions, referrals from Protective Services and the Juvenile Court were lower than expected. The pressure to prove the Center's viability as a neighborhood service was very high, yet there was reluctance among some neighborhood agencies to refer because they did not want child abuse identified as a Mission District problem. Within a month, however, the Center had obtained ten families.

The remainder of the Pilot Study focused upon the delivery of services as developed by the staff during its inservice training. For parents, these included:

Group Therapy (special groups were set up for Spanish-speaking parents and for men)
Occupational Therapy (individual and group)
Individual Counseling
Advocacy Services
Emergency Services (Hot Line, Crisis Intervention)
Parent Board
Community Meetings

For children, they included:

Day Care 7:30 a.m. - 6:00 p.m.
Meals (including breakfast, lunch, two snacks)
Extended care for evening meetings
Medical check-up once a week plus emergency care
Developmental and psychological testing
Emergency child care
Individualized developmental programs

Issues--Parents: During the Pilot Program the primary issue was establishing a balance of innovative creative treatment and emotional survival of staff. Initially the staff were willing to try anything. They took on the name of the Center (which they changed to the Extended Family Center) and became an extended family to the families receiving treatment. Staff worked long hours, were always available, rarely set limits with families and generally deprived their own emotional needs to meet the needs of the Center families. Three months into the Pilot Program most of the staff was exhausted and began to withdraw emotionally from the program. The need to find a balance of innovation and staff emotional survival led to several other key issues during this phase.

Within the first two months of the program it became apparent that internal support for staff was going to be essential to help deal with the intensity of the services being offered and the expectations staff had created for themselves. Initially large amounts of time were spent in meetings for peer supervision, supervision by the trained staff (director and researcher) and supervision by consultants. In addition, weekly sensitivity meetings were set up with an outside facilitator to help staff communicate and to give needed space to ventilate anxieties, frustrations, and reactions. By the end of the Pilot Program the staff as a unit began to formulate a philosophy and an approach to better management so that they would not exhaust their energy and would improve the overall delivery of services within the Center. The sensitivity meeting was expanded providing as a time for to have the entire staff to set up and develop Center policies, both programmatic and administrative. Daily meetings were consolidated into weekly team meetings and a weekly business meeting was set up. Care had to be taken that staff time not be so tied up in meetings that they could not meet with families. Staff also set up and agreed to a more organized system for coverage and provision of emergency services that met family needs but did not exhaust the staff.

Most importantly, the staff began to look at their involvement with families and to accept the need to set personal limits for themselves. These discussions were particularly necessary because most of the staff did not have professional training and had to develop their own sense of how they were going to define their relationship to the families with whom they were working. These decisions generally came out of the first crises of accepting the authoritarian role of protecting the child. Staff began to realize the full impact of the protective service nature of their job when court intervention

to protect the child became necessary on two cases during the Pilot Study. This dilemma was particularly strong for the Parent Consultants whose role identities were least clear between being staff and being parent representatives.

As staff began to assume more therapeutic roles with the families, the Center developed a more cohesive philosophy of parent involvement and control in the Center. Parents were encouraged to rely more on each other and to view staff members as facilitators to develop a peer group rather than as a peer group itself. The period of transition from the intensive staff involvement as an extended family to the staff as facilitators of the parents relating to peers was difficult for all involved. The Pilot Study families sensed the change in staff attitudes and level of involvement and resisted by demanding more and criticizing staff commitment. However, the transition was eased by the Center accepting 15 new families for service and three new staff members when the program moved into full operation at Year II.

In addition to transition problems, the development of peer groups brought its own unique problems. Several parents aligned themselves with other parents sharing similar problems and sometimes tended to reinforce each others' negative rather than positive behavior. This was particularly true of parents with drug problems who supplied each other with drugs while at Center functions.

Issues--Children: The Pilot Program gave the staff an opportunity to identify the childrens' special needs and to begin to develop a more cohesive therapeutic child care program. It was a time for the teaching staff to observe the children and begin to learn how abused children were different from those in a regular day care setting. Our conclusion was that the childrens' needs, rather than being unique, were different only in degree. The children were more disruptive, overactive, withdrawn, or passive. They lacked the nurturing in their home environment that would allow them to utilize (at least initially) an educationally focused environment. As a result, the teaching staff focused on helping the children develop trust, controlled behavior, verbalization, limits, and social action with their peers. It was our conclusion at the end of the Pilot Program that day care was a viable form of treatment for the abused child and that these children needed, for a period of time as yet unspecified, to be in an environment geared to their needs for special nurturance because they lived in an abusive household.

We also decided to remain with the age range of 0-5 years because of the priority need for infant day care and the hope of long-term success in intervention with younger children. We also decided that the older children required a separate program. The staff located a new site for 15 preschoolers and used the original site to serve 10 infants in the second year.

One of the most important issues faced by the day care staff in particular was the parents' reaction to day care and its effect upon the children. Without exception each pilot family at some point became resistant to the day care program. Too often this resentment was tied to changes in the child's behavior which were seen as definite signs of growth by the day care staff.

> Maria, age 3, was referred to EFC by the Public Health Department after she was found to have bruises and belt marks over her back and legs (during a well-baby exam). Her mother, Mrs. J, a 24-year-old Latin woman, admitted to beating the child with a belt because "she's a monster." Maria, upon admittance to the Center, was an overactive child who had great difficulty responding to limits. She continually tested staff with provocative behavior including kicking, biting, throwing objects, and general disruption of all group activity.
>
> Staff interventions were geared toward helping Maria express verbally her needs and frustrations. Maria initially responded only to physical restraint when she became enraged. Gradually, she began to respond to the teacher's continued verbal support: "You are angry. It's OK to be angry if you can't do what you want, but you must talk about it, not hit me." Slowly Maria learned to express her feelings verbally and received positive recognition not only of her wants but of her feelings.
>
> Mr. and Mrs. J were initially relieved that Maria's overactivity decreased because she was at the Center. The first positive response Mrs. J expressed was: "At least when Maria comes here she's so tired she goes right to sleep." However, as Maria began to express her needs and feelings, both parents became very threatened. They viewed the child's verbal expressions as insolence and another form of behavior that had to be "beaten out of her."

As in the case described above, it was essential that the teachers maintain close contact with parents to support their concern about the children and give them a place to express their negative reactions to the changes in the children's behavior, as well as a place to learn how this behavior could be used to maximize their relationship. Both of Maria's parents, in treatment, needed to learn how to express their feelings and needs verbally rather than through acting out behaviors. Throughout the Pilot Program parents complained bitterly about the Center, its organization, its efficiency and the staff. We found that as long as the staff heard and respected the parents' right to complain, the conflicts could be resolved. For some parents, the teachers could never do

right—for others, as the parents progressed in treatment, the need to attack the teaching staff lessened. In fact, in many cases the best relationships between staff and parents often were between parent and teacher who became mutual caretakers of the child.

Issues—Agency: The final issue during the Pilot Program phase was the fulfillment of the Center's contract to evaluate its program. During the first year site visit with OCD, it became apparent that staff energy, particularly of the researcher who was responsible for the evaluation, was being directed into program management. OCD was dissatisfied with the evaluation/research design developed during the first year and recognized that the type of project being developed was too introspective to expect an objective internal evaluation. As a result, the second year contract reflected a change in the research position to the position of associate director in charge of day care services. In addition, OCD required that the Center hire an external evaluation team that could develop and carry out an external evaluation of the program. This was agreed to by Center staff and in August, 1973, Berkeley Planning Associates were hired to do a two-year evaluation of the program. OCD agreed to add additional money to the grant to pay for the evaluation. (Please refer to the Executive Summary of the BPA evaluation for details of the design evaluation and results.)

YEAR II—JULY, 1973 - JUNE, 1974

Activities: The primary activity of the Center's second year was expansion of the program to full capacity. Expansion included hiring new staff, accepting new referrals and formalizing procedures and program materials developed during the Pilot Phase.

The following program was offered to children during the second year:

1. An infant center for 10 children, ages 0 - 2-1/2 years;
2. A preschool center for 15 children, ages 2-1/2 - 5 years;
3. Transportation to the Center;
4. Breakfast, lunch and two snacks;
5. A weekly medical check-up by a nurse practitioner;
6. Coordinated medical program with child's pediatrician;
7. Weekly observations by a child development consultant;
8. Periodic developmental testing;

9. Individualized developmental program to enhance child's physical, emotional, and social developments;
10. Individual rehabilitation for physically or emotionally damaged children, i.e., physical therapy, speech therapy;
11. Emergency out-of-home care when parent was unable to cope with child;
12. Child care for all parent meetings; and
13. Voluntary foster placement when requested by parent.

Services for children who were in out-of-home placement included:

1. Visits to the child in the foster placement by staff and parents;
2. When possible, inclusion of child in day care program while in placement; and
3. Supplemental services to child as requested by foster home and/or placement agency.

Each parent enrolled in the Center's program committed him/herself to a minimum of four hours of treatment per week. Where possible, this commitment was fulfilled in attendance at two hours of group therapy and two hours of occupational therapy. For some parents it was necessary to develop a more individualized program in order to meet their specialized needs. The full range of services to parents during the second year included:

1. Occupational therapy—two groups available two hours/week;
2. Individual occupational therapy sessions;
3. Individual assessment sessions with Occupational Therapist—held with each parent every six weeks;
4. Work training program;
5. Monthly dance therapy classes;
6. Individual casework—in home and Center;
7. Individual assessments—held with each parent every six weeks;
8. Couple counseling with male/female social work team;
9. Group therapy—three groups available two hours/week (one Spanish-speaking);
10. Parent Board Meetings—1-1/2 hours/week, open to all parents;
11. Community Meetings—once every six weeks—general meeting with all staff in attendance to discuss program, open to all parents;

12. "Hot Line"--seven days/week, 24 hours/day;
13. Social worker available for emergency intervention after Center hours;
14. Parent emergency fund;
15. Advocate services/agency intervention, help with concrete needs, transportation, child care, finding community resources; and
16. Involvement in community activities on child abuse.

Issues--Administration: The primary issue of Year II was expansion and the adjustment of the entire program from a pilot to a full program. This adjustment was first dealt with by a critical decision regarding intake. After the first year site visit, OCD required that we accept only documented cases of abuse. Although all of the children had sustained an injury, some cases were not documented as inflicted injuries. OCD felt that the purpose of the research was to demonstrate effective treatment in documented cases rather than preventive, and therefore required a change in intake. This change essentially required all referrals to be processed either by Protective Services or the Juvenile Court, the least source of existing referral due to the geographic restriction set by Model Cities funding. The change in intake policy required by OCD presented several conflicts for the Center:

- In order to obtain enough referrals to expand the program (15 additional families) and meet the new intake requirement, Model Cities funding would have to be eliminated from the budget.
- The removal of Model Cities funds would require new funding and opened up the possibility of a change in sponsorship.
- The requirement of accepting only documented cases would cause problems with all referral sources in the city because the Center was becoming known as a resource to use as an alternative to the authorities.

At the end of EFC's first year, the Consortium hired a new director, Luis Diaz de Leon. The hiring of a new director lessened many of the political problems for the Consortium. Mr. de Leon expressed interest and support to EFC recommending that the Center obtain new funding (thus freeing additional Model Cities money for the Consortium's program) but remain under Consortium sponsorship. Mr. de Leon offered more administrative support but still made policy decisions

for the Center rather than involving the Board of Directors. Funding for the second year matching grant was obtained from the California State Department of Health and the Zellerbach Family Fund, a private foundation in San Francisco. A requirement of this funding was city-wide services which effectively ended the original goal of developing a neighborhood service for abused children. However, the staff of EFC at this time made a decision to remain a part of the Consortium because of the Consortium's philosophy of consumer control and because of the identity as a community rather than public agency. Serious consideration had been given to moving into a publicly sponsored agency in order to achieve additional stability and possible long-range funding. The pros and cons of public versus community sponsorship were weighed and the staff felt that the success of the first year program came from the freedom (no matter how unstable) obtained in a community sponsored and controlled program. At the same time, the staff recognized that EFC's program was not understood or accepted by most of the Consortium and this isolation had to be lessened if the program was to succeed in the community.

Other administrative issues also had an important effect upon the functioning of the Center. The introduction of a formalized evaluation plan (by Berkeley Planning Associates) revealed the inadequacy of administrative matters within the Center, particularly in the area of records and an organized method of knowing what was being done and by whom. Staff concern and energy throughout the Pilot Program had been on creating and delivering services. During the second year the emphasis began to change to the inclusion of responsibility for documenting as well as delivering services. Further structure for records, statistics, and procedures for handling day-to-day matters were again developed and implemented by staff not only in regular meetings but in several all-day workshops. After collection of data had been completed by the BPA staff, several of their staff offered technical assistance to the Center administrators and were invaluable in helping the Center begin to formalize its procedures.

In October 1974, the Parent Consultants were hired full-time and assumed responsibilities of social workers. The second year report spoke to the unique needs of this part of the Center program:

> Since October the Parent Consultants have been permanent staff members. Each participates as a co-leader with a staff member in group therapy and one also assists the Occupational Therapist in the Occupational Therapy meetings. The role of the Parent Consultant has pitfalls that must be closely watched if it is to be successful. We found

> that the Parent Consultant who had had group treatment and a very supportive helping relationship at the time of her abuse has functioned more easily than our other Parent Consultant who had very authoritative help at the time of her abuse. Both Parent Consultants have had to deal with their anger and jealousy of the parents enrolled in the Center.

Throughout the second year the primary staff issue was clarifying their relationship with families and continuing to protect themselves from burn out. The improvement of administrative structures and support for staff assisted in the process. However, each new staff member repeated the experience of the initial staff and seemed to need to go through a period of overextension before a personal limit of involvement could be set. Refinement of treatment philosophy and approach also helped clarify limits for both staff and families. More emphasis was placed upon treatment process, intake was refined, treatment stages were clarified, and termination criteria were developed. Parents were encouraged to begin to view the Center as a part of their development rather than the answer to all their problems. Continued emphasis was placed upon parent involvement in the program and peer involvement with each other.

Issues--Parents: During the second year of the Center, the staff and parents were able to refine and develop the treatment philosophy and approaches. The two primary issues dealt with in parent treatment were the development of parent participation in the Center and termination (both voluntary and involuntary). The Center's second year report described the development of parent participation as:

> Another essential part of our treatment has been parent involvement in the Center. Staff is committed to developing a Center which has a valid and meaningful parent participatory program. Such a concept is not unique in the field of day care but is a precedent in the field of child abuse. We have found this approach to have great import in improving self-image and feelings of self-worth--two primary dynamics of child abuse. On an individual level parent participation means communicating the importance of the parent to the program rather than vice versa. Our role as a demonstration program has given us the opportunity to share learning and experimentation with parents. Our expression of the parents' value to the program is based in the Center's philosophy that abusive parents are best able to help abusive parents. It is carried out in our Parent Consultant program, through the activities of the Parent Board, and through the Center's activities in organizing abusive parents to affect legislation and services for child abuse. On February 15, 1974, eight parents from our Center testified before a State Senate Hearing on child abuse legislation. We have been asked to testify further

in Sacramento and parents are beginning to participate in conferences on child abuse in the Bay Area. Our parents have also been asked to participate in the activities of the Child Abuse Council in San Francisco. Although these activities are not a major emphasis of our program, they are a very meaningful outgrowth of the Center's political philosophy of treating abusive parents as respected adults who can control their own lives. The Center's Parent Board now has a regular membership of four to six parents who have organized a number of Center activities and continue to help resolve problems in the program. In February they participated in the selection of a Teacher Assistant for the staff and will be involved in any future hiring of staff.

Another important treatment issue faced during the second year was the termination of families from the program--both voluntary and involuntary. Termination guidelines were set up to help the staff and parents assess when a family was ready to leave the program. These guidelines included:

- the child's safety in the home
- the quality of the parent-child interaction
- the parent's ability to deal with problems effectively
- the child's readiness to leave therapeutic day care
- resources available to the family in the community

The following case describes one of the first families who terminated with the Center:

Rebecca, age 11 months, was referred to our Center by a Protective Services worker working with Rebecca's mother, Ms. Tracy, age 23. When Rebecca was 3 months old she was placed in a foster home by the Juvenile Court because her mother (after revealing to her Protective Services worker that she had fantasized murdering Rebecca for several months) attempted suicide herself. After the placement Ms. Tracy received psychiatric help, obtained a job, had a supportive relationship with a new boyfriend, and was willing to become involved in the Center's program if Rebecca was returned to her.

Upon agreement with the Center, Rebecca returned home and entered the day care program. Initially she was a fat, placid baby with no affect who would sit in one position for long periods of time. She was unable to protect herself from the other children in the Center and rarely cried even when hit. At home, Rebecca had nowhere to play; her mother, Mr. Smith (her mother's boyfriend), and she lived in a one-room apartment totally occupied by furniture. The apartment was in the center city with no outdoor play areas. During the time Rebecca was in the Center (11 months), the staff worked with her around expressing her needs, becoming more assertive and involved in her environment.

Ms. Tracy initially cooperated with the Center program, participating regularly in group and occupational therapy. She continued to struggle with inadequate feelings about herself which caused

problems in her relationships with Rebecca and Mr. Smith. As her own needs were met she was less demanding upon her family members. Ms. Tracy had a close relationship with her Parent Consultant who helped her become more realistic in her expectations of Rebecca and gave her support to move into more adequate housing in a better area of the city.

After the family moved, Rebecca made rapid progress in the day care center. The staff was able to help both parents accept Rebecca's changing personality by recognizing the positive growth she was making. During this period both parents were resistive of parent treatment. Ms. Tracy was extremely critical of the teaching staff's relationship with Rebecca. She continually complained about the care in the day care center and moved in and out of relationships with several staff members.

After several months of disruptive tactics by the parents, the staff confronted both parents by offering them the opportunity to return to Juvenile Court to request termination of the Court order to work with the Center. Once the parents recognized that the staff was not going to participate in their resistance, both continued in their involvement, and termination was voluntarily achieved several months later. Plans were made for Rebecca to continue in out-of-home care with a babysitter obtained by a Center staff member. Ms. Tracy had become pregnant (by plan) and indicated a desire to voluntarily participate in the Center's groups so that she would be better able to care for her new baby.

During the second year court intervention was used to obtain parental cooperation with the Center's program on a number of occasions; however, there were only a few cases in which the Center refused services to a family because they could not offer enough services to adequately protect the child.

Issues--Children: During this year the teaching staff continued to refine their observations of the children and develop an early childhood education program geared to the specialized needs of abused children. Subjective and objective observations of the children reported in the Second Year Progress Report are as follows:

Observations of the Children--Subjective:

Various children at different stages of treatment at the Centers have and continue to display behaviors that are characteristic of abused children reported in the literature. Among the behaviors that are more frequently found at the time of initial enrollment of the children are: apathy, depersonalization, self-destructiveness, high distress, flinching and compulsive mimicking. Behaviors that are displayed both initially and maintained over a longer period of time are: hyperactivity, destructiveness, slow language development, clinging and distressful whining, seemingly unprovoked anger, a delight in provoking anger in both peers and adults, and bullying.

Many of the children who enter the Center with withdrawn types of behavior have changed and become more assertive and aggressive. This change tends to occur along with some improvement in language development. Characteristics of the children two years and under upon entrance to the program were almost evenly divided between apathy and anger. The three and four year olds were predominantly aggressive upon admittance. Three children showed mixed and/or less extreme reactions.

Observations of the Children--Objective:

The formal assessment devices used are the Denver Developmental Screening Test, the Bayley Scales of Infant Development and the Inventory of Developmental Tasks (IDT).

The Denver is administered by San Francisco General Hospital personnel. It was chosen as the standardized measure because it spans the age range of all the other children enrolled and is widely used as a developmental measure for all children. Results from the initial Denver tests showed that the group as a whole tested below the norm for their age. Language milestones were the most frequently failed followed by fine motor skills. These results are consistent with staff observation.

Results of the Bayley and IDT have been used primarily to supplement program material and activities. The IDT has been particularly valuable in helping parents understand how their child is developing. Because the results are presented in graph form, the parent is able to see the complexity and various levels of childhood development. The graph also helps a parent understand where his/her child is developmentally without placing emphasis upon normative comparisons.

The issue of children graduating from the day care center had special implications for the children's program because the children who were graduating had served as role models for the newer children. Now the staff had to assess the implications of removing children who were beginning to have positive interaction both with staff and children from the group. This issue speaks to the original concern of placing abused children in a special day care center. We recognize that children in their peer interaction stimulate language, relationships, curiosity, and help each other in the development of a stronger sense of self. As the children improve, through their family's therapeutic involvement with the Center, arrangements are made for them to be cared for in alternative child care settings where they will receive this peer stimulation. The absence of children who have reached a higher level of development clearly takes away an important source of stimulation for newer arrivals. However, at the end of the second year the staff continued to feel that the specialized needs of the abused child required a specialized setting with staff trained to cope with

those needs. Staff also recognized that there is a point in a child's individual development where he/she will benefit more from a different child care setting and must therefore leave therapeutic care. To give EFC children access to the benefits of interaction with children of normal development while they are at EFC, the day care staff began visiting other centers in the Consortium and spent several hours daily at a nearby mini-park which is utilized by four other child care centers.

YEAR III—JULY, 1974 - JUNE, 1975

Activities: The third year of the Center, as in all 3-year federal demonstration projects, was overshadowed by the question of continued existence. The Center developed at the beginning of the third year a strategy to meet both the needs of the Center, now operating at full capacity with a defined program, and the reality of survival. Administrative changes were developed that changed the Center from a one person management focus to a diversified management responsibility. There were several reasons for this change but an overriding concern was to free the Director from day-to-day program responsibility so that her time could be spent on funding issues. In addition, this change allowed the Center to begin to share administrative responsibility in a more organized and less personalized fashion, thus assuring the presence of built-in structures regardless of who filled staff positions.

Throughout the second year the Consortium's political problems had continued. Although EFC (through the Director's position) had become more active in the political issues and the day-to-day administration of the Consortium, EFC continued to remain an isolated part of the program. When Mr. de Leon resigned under pressure, he recommended that EFC find separate sponsorship. Again the EFC staff and parents met and decided to remain part of the Consortium for the final year of federal funding.

The hiring of a new director, Glen Brooks, brought major changes in the relationship of EFC to the Consortium. Mr. Brooks was hired because of his administrative skills and the Board directed him to set up an effective administration structure which would include Board involvement in policy decisions for EFC. As a result of this directive, the Board assumed control over EFC policies for the first time since it delegated to responsibility in 1972. The issue of EFC's relationship with the Consortium was taken to the Board of Directors in the fall of 1974 and the Board committed itself to continuing the

project at the end of the demonstration phase as a permanent part of the Consortium program. An EFC parent was elected to represent EFC parents on the Board of Directors and a Consortium-wide staff committee was set up to recommend policy changes to the Consortium Board that would be needed to incorporate EFC into the Consortium on an equal basis to other Centers. Results of that committee are available in the BPA 7th Quarterly Report.

During the third year staff continued to be aware of the effect of administrative functions upon the quality of services being developed. EFC was created upon the principle that centralized administration and bureaucratic hierarchy limited the effectiveness of an innovative program. As a result, whatever structure that was put into the program was created from a demonstrated need. As the program grew and staff changes were made, management problems were directly reflected in parental complaints about the lack of availability of and reliability of staff, and lack of overall organization that inhibited them from receiving services.

Staff response was a workshop at which they looked at various issues within staff that were affecting their performance. The need for reorganization and structure was recognized and significant changes were made. A middle-line administration was created to allow for more direct program supervision while freeing the Director for administrative duties and to obtain funding beyond the demonstration grant. The position of Associate Director was eliminated; the positions of Head Teacher and Head Social Worker were given supervisory responsibility for the service programs. The Director, Administrative Assistant, and Secretary were given responsibility for administrative matters of the Center. Job functions were redefined and a weekly administrative meeting of the five administrative/supervisory positions was held to review all administrative matters. More significantly, issues that previously had been taken for decision to the entire staff were assigned to that team. This process was seen as necessary by the whole staff and as much as possible staff gave feedback and/or input into those decisions.

Changes in management functions were also stimulated by changes in the Consortium. Mr. Brooks assumed a more active role in administering EFC than any other previous executive director. He also involved Ms. Ten Broeck in more overall administration of the Consortium. This involvement was crucial in integrating EFC into the sponsoring agency and creating a space for the Center to develop into an ongoing program. These changes had a significant effect upon

the entire Center by distributing the administrative functions from the Director to more of the staff both within the Center and the sponsoring agency. The final result of these changes was the decision to phase out the position of Director of EFC at the end of the demonstration grant. The position was replaced by a Special Program Coordinator funded half-time to administer EFC and half-time to develop other specialized services within the Consortium. The position of Administrative Assistant at EFC was also eliminated and the fiscal administration was assumed by the administration of the Consortium. As of July 1, 1975, EFC became on ongoing program of the Consortium administered by the central office of MCCC.

Issues--Staff: During the third year EFC faced its first turnover of staff. By the end of the second year, two staff members (a social worker and the Head Teacher) had left the program. From July to December of the third year five staff positions were vacated and two new teaching positions were created making a total of seven new staff members joining the Center. The staff turnover occurred primarily in the social work staff and among people who had been with the program over a year. The primary reason for staff leaving was their reluctance to begin a new program in the structure set up by the Consortium. Of the staff hired to fill the vacancies one was discharged before completing probation; the rest remained throughout the third year of the program.

The staff turnover created many problems as well as challenges. For the first time the Center had to train staff into an existing rather than developing program. In addition, there were now different levels of staff experience within the program. This created strain among the new and old staff and created some disharmony among a staff that had been singularly united. At the same time it aided the program by creating more structure and organization and also brought in new points of view and enthusiasm from people not tied to old experiences and set ways of doing things.

New staff members were assigned to an experienced worker for daily training as well as given supervision by the program head. Additional social work training was obtained through weekly training sessions for all social workers in the Consortium run by the Director of EFC and the Social Service Coordinator of the Consortium. Ongoing peer supervision was also provided in weekly team meetings where all cases were reviewed by the social work team. Weekly meetings of the teachers were also held to review the children's progress and to discuss

various approaches in the classroom. Continued emphasis was placed upon communication between the social work and teaching teams at the weekly business meetings of the entire staff. These meetings were used to discuss administrative matters as well as cases to assure staff communication and group decisions on any major problem such as a needed court referral.

The staff continued to meet once a week for a sensitivity session with an outside facilitator. The primary purpose of the sensitivity sessions continued to be giving staff adequate support for their needs so that they could meet the needs of the families. Problems between staff members, as well as staff members and families, were brought to this meeting. As staff became more comfortable dealing directly with communication problems outside of the group, the focus of the sessions was changed to examine broader problems facing the Center. These issues concerned the changes in philosophy of treatment, how to handle certain case problems, and how to adjust to the changes facing EFC as a result of the end of demonstration grant. These sessions were invaluable in helping the Center move into a more structured agency status without losing its uniqueness of open decision making and absence of hierarchies.

The sensitivity group was also a central factor in helping new staff integrate into the program. Issues of new versus old staff and the inclusion of men into a predominantly female (and feminist) staff were examined in the sensitivity sessions. These meetings were also instrumental in helping the Center keep its creativity and openness to new ideas while developing a structure and an identity as an established agency.

During the third year the Center began two new programs (Parent Education Group and a Parent Aide Training Program). Both these programs are described and evaluated in the 6th Quarter Report published by BPA.

Issues--Administration: The effect of the funding struggle forced the Center to look at its viability in terms of the number of families being served. The high ratio of staff to parents was seen as a benefit that could be reduced without loss of quality. The ratio of staff to children was considered essential and the decision was made to begin to move to an agency status serving 50 families with a limit of 25 children in day care served by the same amount of staff. All grants written for fiscal year 1975-76 included these numbers and client flow through the Center allowed the staff to begin increasing the number of families receiving service during the third year.

However, the issue was also faced that funding changes would require new criteria for families and termination became an issue not only for case management but because of agency requirements. Future funding (an anticipated LEEA grant) required that the agency begin a new program not simply continue the OCD demonstration grant. In addition, final award of that grant came very late in the year (June, 1975) so that staff was unsure if any program would be available July 1st. This uncertainty created great tension among staff and families and resulted in very poor termination plans for families still active in the program at the time of transition from the OCD to the LEEA grant. The BPA 7th Quarter Report evaluates the affect on parents of the transition of the Center and the disruptions caused by funding problems.

Issues--Parents: During the third year further refinement and a shift in parent treatment occurred. Throughout the first two years the staff had operated from a philosophy that treatment of parents could be best effected by encouraging and allowing a dependency that would help parents develop trust and therefore a willingness to change behavior. The staff was successful in developing that trust and meeting dependency needs; however, the move into a phase where behavior changes could occur was less successful. Staff began to assess how they were implementing the original treatment philosophy and realized that they were becoming limited because they did not allow for the parents moving from problem recognition to problem solving. Changes in treatment philosophy were made. The staff accepted a change in focus that viewed the Center's program as an initial step in treatment for parents and children rather than a center that would offer treatment from beginning to end of the problem. The Center recognized that its staff and facilities were not capable of meeting the long-term needs of parents and children. It also recognized that the Center philosophy and staff were uniquely able to offer families an initial phase of treatment that we chose to call "reparenting." The Center was best able to work with parents who were in the initial phase of treatment where there is a need to develop a relationship that would allow parents to gain trust in others (particularly providers of treatment) and in themselves. This phase is crucial to allow parents to move on to more structured forms of treatment that could bring about specific behavior changes. It is important to stress that the EFC program was able to change the immediate acting-out behavior of abuse. The statistics of reabuse among the families were high when viewed

in terms of percentages (19% repeat of all types of abuse). However, this statistic needs to be considered in context of how it was obtained. Any incident of injury to a child involved in the program (whether inflicted or due to parental omission such as injuries due to a fall from an open window) were counted as reabuse. In addition, the knowledge of injuries was high because all children were examined daily by the day care staff. In only 4% of the cases were the injuries deemed reportable to the authorities--i.e., an injury and social situation that required outside intervention to assure protection of the child. The Center's program was not as effective as we had hoped in changing the basic social problems in the family such as drinking problems, drug addiction, marital problems, lack of employment, etc. Please refer to the BPA Evaluation Summary for an overall assessment of changes in family functioning.

At the end of the third year the EFC staff restructured the treatment program to reflect its change in treatment approach. The program described below is a brief description of the services planned for the fourth year. Parents are to be assigned to groups and social workers according to what phase of treatment the parent is in at the time of entry into the program. The three treatment phases will be dependency, problem solving, and graduation. Most parents enter in a dependency phase and are introduced to the program through a Socialization Group (which includes Occupational Therapy) and are assigned a social worker (generally a Parent Consultant) who focuses upon their dependency needs. When the parent and Center staff feel that the parent is connected to the Center and beginning to be aware of his/her problems, the parent will move to the problem solving phase and join a Problem Solving Group where support is given to understanding and changing his/her behavior. Parents will also be offered individual and group help in changing their child rearing patterns. Throughout all of the phases of treatment, parents will be clear about the need to refrain from abuse--the approach changes, however, from intensive support and direct action by staff to prevent abuse,to the parents' independent control through understanding of their behavior and independent problem solving. When the parent and staff feel that the parent is able and willing to deal with his/her problems without the intensive support of the Center, the parent will enter the graduation phase. Where possible, a referral will be made to an ongoing service in the community. Voluntary ongoing support groups will be offered at EFC to all Center graduates on a drop-in basis to ensure that the support and caring obtained at EFC is available to any parent who feels they need it even if they are no longer enrolled in the program.

Another treatment issue during the third year was the effect of the parent participation program in the community--both upon the parents and upon the community at large. One of the most unique aspects of the EFC demonstration project was the program's ability to relate to and involve abusive parents in their own treatment and the events affecting their lives. During the third year both the benefits and drawbacks of this involvement became clear and changes in the program were developed to cope with its negative effects.

Within the Center parent participation was always dealt with as part of the treatment program. If parents' therapeutic issues affected their activity in a Center policy or political struggle the staff had knowledge of the parent's problem and could help the parent recognize when his/her personal problems were affecting the discussion at hand. In fact, great therapeutic progress was made through parental involvement in policy and political issues as shown in the following case.

> Sally, age 26, the mother of three children ages 4, 2, 11 months, and her husband were referred to EFC by protective services who felt that the mother was unable to care for the children full-time. Sally had a long history of violent behavior towards others due to uncontrolled epilepsy and mental retardation. She was also paralyzed on her left side and had limited use of her left arm, hand, and leg although she was mobile. When under stress she would respond by having seizures or by striking out. She had successfully cared for her first two children under the supervision of her husband's family. However, the family would no longer help because her third child was not her husband's child. All of the children exhibited behavior problems which Sally responded to by exerting physical control. Although the children were never severely injured they were hit with great force and frequently in the face. In addition, Sally functioned with the children as another child and spoke of her oldest daughter, age 5, as the Mama.
>
> Sally was extremely disruptive in the Center. She wanted to remain in the day care area and "play with the kids." She frequently interrupted the children to get one of her children and would drag the child screaming from the room. At times she would fight with the staff, once throwing a pot and once creating such a scene on a street corner that the police were called and she was hospitalized.
>
> The one area that Sally responded to was her involvement in Center groups, particularly the Parent Board. Because she came to the Center every day all day she received intensive support and intervention from staff. She also developed friendships with two other parents who became very protective of her. As she worked on her problems it became apparent that Sally's seizures were manipulative and that she was not mentally retarded. When treated with firmness and respect she began to control her own behavior particularly in meetings. Frequently it was necessary for her to deal with her own struggles through the Center groups. She would often explode and argue in a totally irrelevant manner to the subject at hand. To

the parents and staff at the Center these explosions were understandable and when they totally stopped group interaction one staff or parent would help Sally leave until she gained control.

Eventually Sally's needs grew beyond the resources and skills of the Center staff because she demanded excessive staff energy that needed to go to other clients. She enrolled in a 4-hour school program for developmentally and physically handicapped adults and transferred much of her intensive involvement to that program. However, she remained active in the Center Parent Board and was one of the most effective parents to interview prospective staff members. Her favorite question was: "What would you do if you came to the day care center one day and found me choking one of my kids?"

Unfortunately, as parents became involved in activities outside of the Center with personnel who were not familiar with their personal struggles, problems quickly ensued.

Terri, age 27, mother of three children, was referred to the Center due to abuse of her oldest child, age 3. She was an active, enthusiastic member of the program attending groups regularly, active in the Parent Board and extremely verbal about her problems with her children. She was particularly close to Mrs. Hall, parent consultant, and wanted to become involved in community activities in child abuse. Despite her apparent changes in her attitudes about herself, staff felt that her awareness was superficial and observed that she easily became depressed about her relationship with her children.

During the final year of the demonstration project, EFC joined the S.F. Child Abuse Council in a joint effort to train volunteers to staff a Hot Line for parents in stress. Parents at EFC were recruited as volunteers for the Hot Line as well as trainers to help other volunteers understand the stress that parents who abuse endure. Terri volunteered for the program, was interviewed by a panel of parents, staff and a consultant and approved for the training program. At the last session of the six-week training program for Hot Line volunteers, the EFC parents were asked to make a presentation to the other volunteers. Unknown to the EFC staff, the press was invited to this session. The parents were nervous but all quickly agreed to the press coverage.

After the session Terri became severely depressed. She reverted back to many of her previous behaviors—drinking, not sending the children to school, hitting Matthew, her oldest child. When asked what had happened, Terri replied, "I knew I shouldn't have gone on T.V. but I couldn't say no because everyone at the Council had been so nice and I knew how important it was for the Council. But when I saw myself on T.V. I knew it was a lie. That I couldn't do all the things I said I could do. Deep down inside I know I'm no good and I'm never going to be any good."

Within three months the Center had to refer Terri's case to the Juvenile Court because she totally refused to cooperate with the Center and the children remained in jeopardy.

From experiences such as the one described above, the EFC staff became more judicious in encouraging parents to become politically active and remained more closely involved both with the parents who did choose to become involved with other agencies as well as the agency personnel working with the parents.

The other side of the problem with the Parent Participation Program was conflict it created between EFC and other agencies. EFC functioned as a unique agency because for two years it had no external input except through the Advisory Board which served only in an advisory capacity. It also had a non-professional staff which operated a unique and at times controversial program. The EFC staff's insistence on parent involvement in the community programs for child abuse was both supported and resented. During the first two years EFC staff did little to enhance its relationship with other agencies, particularly those active in the S.F. Child Abuse Council where EFC chose to demand a role for parent participation. The staff was overwhelmed by the demands of the families, the Center director was constantly embroiled in Mission District politics and the mistrust of the agencies was generally responded to with defensive distrust. Unfortunately, the people who suffered were the parents at EFC, particularly those who chose to become active in the Child Abuse Council programs. The parents frequently found themselves trying to defend EFC on issues they did not fully understand. They were unprepared for and confused by the attitudes held by professionals they met at the Council towards abusive parents in general and towards EFC in particular.

As EFC staff became aware of the negative effect the political disputes had upon parents, they became more realistic about their own attitudes towards other agencies and helped parents learn to understand the realities of how politics can affect programs and the people they serve. Staff also assumed more responsibility for developing relationships with other agencies built upon respect for the services each could offer. As the staff accepted their lack of omnipotence in curing all the social ills affecting the families at EFC, they accepted the importance and role of all the agencies involved with the families. This change in attitudes came as the staff rather than the director alone began to be active with the Council both in general meetings and on committees.

Issues--Children: During the third year program for children at EFC, a refinement of direct work with the children continued. As there was a shift in the Parent program there was also a shift in work with the children. Emphasis

was moved from individual therapeutic work with the preschoolers to a more traditional group setting for preschoolers. As more demands were placed upon the preschoolers they responded to a group orientation and were able to graduate into a non-therapeutic environment. This change in emphasis was instituted because many of the children had been in the program over three months. However, staff noticed that new children integrated into the program with less difficulty when the program was geared to a group rather than individual program.

The infant center continued the emphasis upon the one-to-one relationships with the children under two years and prepared the two-year-olds for graduation to the EFC preschool. The infants continued to be more withdrawn and required a great deal of stimulation, physical warmth and lap-holding.

The day care centers developed curriculum material and daily program activities devised from the earlier observations of the children. A detailed description and evaluation of the day care program can be found in the BPA 6th Quarter Report. Appendix 3 of this report is a review of the results of the formalized testing administered to the children by the Project's Associate Director, Steve Stripp.

PROGRAM COMPONENTS: CONCLUSIONS

The EFC program was divided into four components: Parent Services, Children Services, Center Services, and Staff Services. This section of the report offers conclusions about each component. Specific details and evaluation of each component can best be obtained from the BPA Quarterly Evaluation Reports. The following list indicates where specific topic areas can be found within the Report series.

Subject:	Refer to Quarterly Reports:
Benefit-Cost Analysis	1st, 2nd, 3rd, 4th, 7th
Goals Assessment	1st, 2nd, 4th, 5th (appendum to Goals)
Evaluation of EFC Day Care Program	4th, 6th, 7th
Process Evaluation of Parent and Children Services	2nd, 4th, 5th, 6th
Parent Evaluations of EFC Program	2nd, 4th, 6th
Client Impact Evaluation	1st, 3rd, Client Impact Report
Case Studies: A Comparison	2nd, 3rd, 5th
Evaluation of EFC by Other Agencies in the Community	2nd, 3rd, 4th

In addition to the Quarterly Reports BPA has written an Evaluation Summary which summarizes the major findings of the Quarterly Reports as well as offering a final perspective on the evaluation.

PARENT SERVICES

The final staff assessment of parent services is that the EFC approach--i.e., a Center that is geared to meeting the needs of abusive parents in a non-authoritarian group setting--is invaluable in engaging non-voluntary highly resistive parents into a treatment process. With very few exceptions (4% of all families served), there were significant changes in the parent-child relationship and the children remained in their own home. However, it is also recognized that EFC services alone are not sufficient to bring about long-term changes in the parents' underlying behavior patterns that caused the family dysfunction. The EFC model is a unique means of helping parents become engaged in treatment and develop the self-motivation needed to solve their underlying problems as well as prevent reabuse. The Center's philosophy and

staff were uniquely capable of providing the atmosphere and support system necessary to bring about problem recognition and self-motivation. It is important to also identify, however, that the Center approach had limitations and it is not the total solution to the long-term problems that result in child abuse. It is our conclusion that an EFC approach has its validity in keeping children at home, preventing repeat abuse, and beginning the treatment process. The EFC model succeeds with families that most traditional approaches are unable to reach. However, once the parent achieves recognition and self-motivation it is important to offer additional kinds of services that can develop and foster behavior changes.

Realistically it is important to give guidelines to the length of time needed to offer the services based on the EFC model. On the basis of the EFC demonstration program, we estimate that most parents require at a minimum 3-6 months in the "dependency stage" prior to moving to the "problem solving stage." We also estimate a total length of service through the "graduation stage" to be 9-12 months. Families enrolled in the demonstration phase of the EFC program remained active anywhere from 4-24 months. Almost all the families who were ever involved with the Center have maintained contact with the staff on an informal basis. We remain committed to the principle that a child abuse case is never closed and encourage parents to renew their contact whenever they feel they need support or caring.

Occupational Therapy: EFC was one of the first child abuse programs to offer occupational therapy as an ongoing form of treatment for the abusive parents. The three-year period demonstrated that the use of a non-verbal therapy is extremely beneficial both diagnostically and in treatment. Parents were extremely enthusiastic about the OT activities. In fact, during their initial involvement in the Center they usually cited OT as the reason they came to the Center. Most of the parents were also able to gain understanding of their behavior through their work in Occupational Therapy and used the activities as a therapeutic tool to express anger as well as other emotions.

Parents utilized OT in very different ways. For some parents it was a means of filling up time, particularly for the women. Several mothers came to the Center daily for company and worked on their OT projects at the same time. For the men it was a reason to come to a place they saw basically oriented to women. The men chose projects involving leather, wood, and other "masculine" activities. Some parents utilized the projects, particularly

leather work, to relieve tension and anger. One parent remarked, "After I bang with that mallet I can go deal with my kid and not feel like I'm going to kill him." Most parents saw OT as fun because it was for them and they didn't have to "talk about problems all the time." However, several parents saw their progress at the Center reflected through their OT projects. Parents enjoyed showing the difference between their first projects and the work they did after things got better at home. The more verbal parents utilized OT as a therapeutic tool and were able to see how the dynamics of their interpersonal struggles were reflected in their work in OT.

Casework Services: Individual casework was the foundation of the parent treatment program particularly for parents who refused to come to the Center. Despite our initial reluctance to utilize traditional methods at the Center, it is clear that casework contact at the Center and in the homes was the basic means of keeping parents involved and protecting children. Many parents were initially reluctant to become involved in groups and needed the support of an individual relationship before they could respond to the entire Center program. Individual contacts were also key to meeting dependency needs on both an environmental and emotional level. The needed change from "doing for" a parent to "doing with" or supporting the parent's doing for themselves had to be done both on an individual and group level. It is our conclusion, however, that the individual relationships were successful because they were not based upon one worker assigned to one parent. Parents were encouraged to relate on an individual basis with the staff they felt comfortable with rather than only to their "identified" worker. Rotating staff relationships were also built into the program to encourage parents to relate to all staff. Through the assignment of a scheduled "Hot Day" person who handled emergencies and concrete needs for all families during the day and a rotating staff schedule that covered emergency calls after Center hours and on weekends, parents came in contact with all the staff and found different people to meet different needs.

Group Therapy: On the basis of the three-year experience with a variety of group approaches, we conclude that group therapy is the most effective mode of treatment for parents. It is effective because it offers parents peer support and gives parents a perspective on their problems from fellow parents as well as from staff. As discussed earlier it is important to structure

groups so that parents who are ready to change behavior can be involved in a problem solving group separate from parents who are involved in the initial phases of developing a treatment relationship. We would stress that these groups should not have rigid distinctions and the change in groups should be made by a joint decision of parents and staff.

CHILDREN SERVICES

The effective role of therapeutic day care as a treatment modality for abused children has been demonstrated by this project. All of the children enrolled in day care made significant and often dramatic changes in their behavior. The day care program was crucial in increasing the child's physical and emotional development up to age appropriate levels. The children became more responsive, pleasant, and easier to relate with which rapidly enhanced their relationships with their parents. Exposure to a positive nurturing environment allowed the child to continue to grow at his/her rate of development despite the initial absence of positive nurturing at home. It is our hope and belief (which can only be substantiated by longitudinal research) that the cycle of generational abuse has been modified if not interrupted by the positive caring these children received while their parents were in treatment.

We are convinced that abused children need to be placed in a therapeutic setting for an initial diagnostic period (from one to three months) when the parents first enter treatment. However, most of the children are ready to leave therapeutic care before their parents are ready to leave treatment. Children remained in the EFC program from 4-24 months. Because the children benefit from normal peer contact and develop in new areas after they leave a therapeutic environment, the timing of graduation needs to be carefully assessed. The problem is that most regular day care centers (where a child can be graduated to) are work-related or enrichment programs which are not set up to deal with parents who have special problems and often reject the child because the parent is too disruptive.

We also learned during the three years that the day care component is as important to parent treatment as it is to child treatment. Day care is a practical, observable service that abusive parents need and generally (although there are exceptions) welcome. Many parents will attend therapy groups just to get day care services. It also provides a needed break between parent and child and lessens the potential of physical harm to the child during treatment.

It is an excellent diagnostic setting because staff often become aware of problems in the family by assessing the child's behavior in day care. Very minor abuse is quickly noted simply because the child is seen and can be examined every day. Relationships between teachers and parents allow for role modeling and (when requested by the parent) formal teaching about child development and how to parent can be offered. It is our recommendation that a day care program for abused children be offered only in conjunction with a parent treatment program so that the family as a whole receives maximum treatment. It is also our opinion that therapeutic day care without supportive services to parents would place the children at greater risk in the home for reasons identified earlier in the report.

CENTER SERVICES

A crucial but often not self-evident part of services offered to families was the Center milieu or approach. EFC was established as a physical entity unto itself so that parents could identify with a physical place that embodied a philosophy. A reflection of this approach were parents' statements that EFC was "a home away from home." It became a refuge for parents--a place to visit, entertain others, and have children cared for as well as themselves. The Center was set up as a home with a minimum amount of office space and a maximum amount of meeting space. In addition to the physical space the Center services included outings, recreational activities, cultural activities, political awareness groups and most important community meetings. Throughout all of these activities the implicit message was "this is <u>your</u> center and exists to meet <u>your</u> needs." At times this message was carried to an extreme and needed to be redefined to its primary purpose of treating child abuse. However, as a treatment approach it is our conclusion that services offered to abusive parents can be highly effective in a Center environment. This does not mean eliminating home contacts. There must be regular visits to the home in order to know the family; however, a Center environment enriches the services offered and takes away from the professional stereotype of the snooping social worker. It also offers a neutral ground for trust relationships to begin rather than forcing help into the parent's private domain. The use of a day care center that has facilities for a parent room or parent center offers an ideal resource for developing a safe place within the context of an accepted service. Parents are willing to tell their friends and family about "the Center where my kids go." Center services are also invaluable in dealing

with the stigma of child abuse. Although the staff never pushed for details or admittance of abuse, they were comfortable and open about the purpose of the Center and parents began to talk openly about their child abuse problems. The sharing and support offered within the Center encouraged parents to begin to speak out at community education sessions in order to help other parents who needed the help and weren't getting it. An example of this involvement is the A case.

> Mrs. A, a Samoan mother of two children, was referred to the Center by a Public Health Nurse who examined her oldest child in well baby clinic on the request of a sister who was concerned that the mother was beating the child. The child had numerous bruises on her body and the mother asked the nurse to help her so that she could stop hurting the child.
>
> Mrs. A was very active in the Center and it was apparent that the abuse resulted from the strain of her home situation which included an alcoholic husband, a bed-ridden mother-in-law, financial problems and a very strong-willed 4-year-old daughter whom she didn't understand.
>
> Both parents utilized the Center's services and within six months the daughter was in a regular day care center. Throughout the services Mrs. A became upset when the label child abuse was used. Although she discussed and dealt with her problems she would never discuss what she had done to her daughter and often became angry with parents who did describe the abuse.
>
> After Mrs. A left the Center program she volunteered to testify at a State Senate hearing on child abuse. The media covered the parents' testimony and all the parents were prepared to talk about the Center's program and the need for more services. None of the parents had been asked to discuss their own situation and none of the three parents who testified before Mrs. A said anything personal. When Mrs. A began to testify she started to talk about the program and then began to cry. Very slowly she described before the committee and the cameras what she had done to her daughter and that she in fact had been a child abuser but now was a good parent. After the testimony Mrs. A talked with staff about how relieved she felt that finally she was able to accept what she had done to her daughter because she knew it wouldn't happen again. Asked why she chose that moment to discuss it openly she stated, "If you hadn't been there when I beat my daughter, I don't know what I would have done. Maybe because I could say it on T.V. other parents will get help too."

STAFF SERVICES

A great deal of this report has dealt with details about the Center's staff and administration. In part this was done because the BPA reports already cover the programmatic material. It is our conclusion, however, that in fact the

mix of services that we offered during the three-year demonstration was not the key factor in the results of the program. Rather we believe that the success or failure of a program ultimately depends upon the people who deliver those services and the type of relationships they are willing and able to develop with families.

Staff Selection: Despite problems and mistakes we remained committed to the original criterion for selecting staff: the ability of any person--with or without training--to develop treatment relationships with abusive parents which are non-judgemental, nurturing and committed to working with that parent as an equal in the treatment relationship. Many "professionally trained" persons have been trained to see themselves as superior to and in control of clients and that the common tasks of nurturing--such as giving a parent a ride, baby-sitting, or watching T.V. with a parent--are not good use of their professional time and skill. In fact, these tasks may not be effective utilization of professional time but they are essential treatment techniques to develop relationships with abusive parents. It is our conclusion that staff who provide services such as those developed at EFC can be identified as professionals when professionalism, rather than tied to training or degrees, is defined as: the ability to understand and establish a therapeutic relationship; the ability to assess human behavior; the ability to offer parents alternatives and ways to change their behavior without being judgemental, controlling, or overinvolved with the parent. These abilities are found in persons who have a great deal of energy, commitment, concern for human dignity and equality, understanding of parenthood and its difficulties, and a commitment to children. With these inherent qualities, it is possible to train people in the tasks of assessment, objectivity and the development of alternatives. It is important to recognize that this type of staff is not expected to have the skills required to actually engage in behavior change techniques. The job of this staff is to reach out and care for some (at least initially) pretty unlikable people. Interestingly, most of the EFC non-degree staff became interested in and received training in therapeutic techniques such as behavior modification, transactional analysis and psychotherapy while on the job. By no means does this approach exclude the professionally trained worker; it simply means that whoever the staff is--MSW's or high school dropouts--the essential qualification must be their willingness to learn and be flexible in their approach with people.

Staff Training: To develop a staff with the above characteristics that is also effective in stopping child abuse, it is essential that the program offer adequate support and ongoing training. If the staff does not have formal training it is important to go over the meaning of a therapeutic relationship and help the staff be clear about how they will choose to define limits with parents, both personally and professionally. It is this area where both professional and paraprofessional staff need training in "reparenting skills." The skill of reparenting involves a special mode of relating to needy adults in a manner that allows them to be dependent without losing their autonomy or self-respect. Many professionally trained workers have difficulty accepting the need to allow (or in some cases foster) dependency while untrained workers have difficulty accepting the need to place limits and maintain a therapeutic rather than personal relationship with the families. The EFC experience found that the most helpful training for both professional and paraprofessional staff was peer supervision and sensitivity sessions where both groups were able to share and learn from each others' perspectives.

Staff Management: Another central part of staff support is the management style. EFC began with a commitment to develop its administrative style to serve the program rather than to develop the program to serve the administrative style. The problems that occurred within the sponsoring agency at the time the program was established resulted in an insularity that in retrospect limited the ability to test the validity of this approach. Much of the initial administrative problems resulted from inexperience and lack of back-up from the sponsoring agency. At the same time it created a unique situation where staff and parents had complete control over the policies of the Center. This control fostered the development of innovative treatment services as well as created unnecessary problems. As a result of the EFC experience even with its individual problems, we conclude that the delivery of the type of services needed to reparent abusive families requires a flexible creative administration committed to the support and growth of its staff. However, it is not necessary to totally abandon all outside inputs and constraints--a fact clearly illustrated by the constructive changes brought about at EFC by the BPA technical assistance and Mr. Brooks' expertise and management skills. Whatever the style of management, the key issue remains that the people most affected by a management decision must have input into the decision-making process. We

believe that the success of the EFC program was to a large part determined by the administration's ability and willingness to utilize a group decision-making approach in the development of policy.

FINAL CONCLUSION: "DID IT MAKE ANY DIFFERENCE?"

The most difficult part of a final report is making conclusions about what it all meant. On a local level the impact of EFC has been significant. The program continues on an expanded basis serving 50 families funded by local and demonstration money. As a result more abusive families receive services and there is now local fiscal commitment to the Center as a community agency rather than as a demonstration project.

On a large scale the model of a family center utilizing day care and parent services has been adapted in several communities across the country, including two federally funded demonstration projects. The staff of EFC has been involved in training staffs for these new programs and has provided extensive written material for communities wanting to learn from our experience. The program of the EFC has been shared with people across the United States as well as with professionals from a number of foreign countries through written material, visits to the Center, and presentations at agencies, community groups, and professional meetings. The Center published one article in Children Today which has been widely distributed through requests for reprints both to EFC and OCD.

The evaluation design used to evaluate the EFC program by BPA was enlarged in scope and funded in 1974 as the evaluation tool to evaluate 11 federally funded demonstration projects. Data from the EFC study will be incorporated into this national study as a means of expanding the impact of the rather narrow research design developed by BPA for EFC alone.

In summation, we can only say that we achieved some of the things anticipated and many not conceived of at the beginning of the project. We believe the continuation of the program in an age where federally funded demonstration projects rarely survive on a local level speaks to the program's local purpose and value. It is our hope that the work of EFC will continue in many forms in many communities and that our experiences both positive and negative will be helpful as guideposts to the refinement of the treatment principles we have begun.

Appendix 1

Description of Parent Consultants

Peggy Jean Hall

Ms. Hall was a black, 32-year-old mother of six children when she joined the staff at EFC. She had been referred to Protective Services four years earlier for medical neglect of her then youngest child. All of Ms. Hall's children exhibited signs of neglect--lack of routine medical care, lack of regular school attendance, poor hygiene and nutrition. Her youngest child was suffering from severe malnutrition due to an untreated kidney infection. The home was often poorly cared for and it was suspected that the children (ages 10 years to 5 months) were left unsupervised while Ms. Hall worked a graveyard shift as a janitor.

Ms. Hall, a bright, insightful woman, utilized casework services to deal with her loneliness and feelings of being overwhelmed by the responsibility of her five young children. She was able to express her anger at her husband and her family as well as her lifelong feelings of inadequacy. Because Ms. Hall received services from a demonstration project, she received intensive medical care and group therapy as well as casework services. Within a year she had made excellent progress in improving the care of her children. Even after she terminated services with the project, she sometimes attended group therapy sessions to maintain friendships developed with other members.

When EFC was started, Ms. Hall was still at home with her children. She had given birth to her last child two years earlier and was anxious to work on a job that would give her an opportunity to help people in the way she had been helped by Protective Services. She was also anxious to increase professionals' understanding of the stress parents experienced and how professional intervention can lessen or increase that stress.

Ms. Hall was an extremely effective staff member. She was able to articulate parents' pain in a way that helped the staff who had not had similar experiences understand and empathize with the parent. She was also effective in supporting fellow workers through the parental "testing" period by describing the many tactics she used on her Protective Services worker and how important the worker really was to her despite her obvious actions to the contrary.

Ms. Hall's most valuable contribution was her ability to relate to parents enrolled in the program. Much of the initial hostility and resistance

encountered in abusive parents was lessened because of Ms. Hall's ability to communicate to parents that the Center and staff were "for real" and could be trusted. Parents were willing to share their feelings and their fears with Peggy because she made no attempt to be other than what she was--a mother of six kids who had suffered a lot and learned a lot and wanted to help others so they wouldn't have to go through the same thing.

Because she had such an intense commitment to the parents, Ms. Hall had problems remaining objective and setting limits. At times she was torn between her desire to help parents and her responsibility to protect children. This conflict was resolved through her participation in peer group reviews of cases and her own development as a skilled social worker.

Sharon Fee

Ms. Fee was a 22-year-old Caucasian mother of a 3-year-old son when she joined the staff at EFC. When her son was three months old he was hospitalized with a fractured skull. One month later he was hospitalized with a refracture of the skull and subdural hematomas. The child was diagnosed as a battered child and referred to Juvenile Court. The child was placed in a foster home for a year and a half. While her son was in foster care, Ms. Fee obtained psychiatric counseling and enrolled in parent education classes. Both she and her husband were seen regularly by a child welfare worker. The family made significant changes in their lifestyle obtaining a regular source of income, getting married, and obtaining adequate housing. The Fees were supervised after the return of their son and had no problems assuming his care. Their case was terminated by all official agencies one year after their son was returned.

When EFC was organized Ms. Fee was at home caring for her son. She was interested in taking the job because she needed additional income. She was also anxious to make something positive out of an experience she had found totally negative. Initially, Ms. Fee had difficulty dealing with her work because of her high level of denial. Although she was comfortable discussing her experiences with the professional network of services, she was unwilling to look at her own actions and responsibilities in abusing her son.

As a result, Ms. Fee also had difficulty dealing with the parents in the program. She was frequently hostile and judgemental and often appeared unable to understand their stresses. When faced with the reality that her performance on the job was inadequate, Ms. Fee began to express the conflicts

she was facing. She admitted to herself and to the staff her role in her son's injuries. She was able to recognize her jealousy of the services offered to parents and her need to see these parents suffer as she had suffered. She also began to deal with the current stresses in her personal life which eventually resulted in divorce from her husband to whom she gave custody of the son.

At the end of the three years, Ms. Fee was a capable, effective worker. She was well-organized, efficient and took on administrative responsibilities as well as casework duties. She was able to relate freely with parents and was generally well-liked because of her honesty and her willingness to tell people the truth. She was particularly effective in setting limits and helping parents take responsibility for their own lives.

Appendix 2

Job Questionnaire Used For Staff Selection

1—Strongly agree
2—Agree
3—No opinion
4—Disagree
5—Strongly disagree

Put # closest to your reaction to the statement.

____ 1. Generally, parents raise their children in the same manner their parents raised them.

____ 2. If a parent did not want to participate in research testing, all other things being equal I would support his/her resistance indefinitely.

____ 3. Battering parents can be helped by watching people who know how to take care of children properly.

____ 4. A research program which divulges information gained in confidence is a detriment to giving service.

____ 5. People who beat a small baby make me angry.

____ 6. I would be unwilling to change my approach to treatment simply because research data showed it was ineffective.

____ 7. If a toddler broke an ashtray I told him not to touch, I would spank him.

____ 8. Experience at doing the job well is as important as any degree or credential.

____ 9. A parent who has killed a child should never be allowed to raise another child.

____10. One member of the team should have final say over issues that members cannot mutually agree upon.

____11. The staff should be careful not to allow battering parents to become dependent upon them.

____12. Administrative staff should support staff members when there is a disagreement between staff and parents.

____13. Abusive parents' opinions about how the day care center is run should be respected and implemented when appropriate.

____14. It is important to have a clear chain of command in an organization and follow it in times of decision-making and crises.

____15. Parents who openly admit their hostility towards their children have the greatest potential for child abuse.

____16. An Assistant should not make a decision until he/she knows his/her Supervisor agrees with that decision.

____17. A teacher should be concerned about a 2-1/2 year old child who will not share his toys.

____18. It's OK to come to work late or leave early as long as you get your work done.

____19. I would be pleased if the children I worked with were friendly and loving to everyone all the time.

____20. It is important that children learn to behave so that they will get along with and not disturb other people.

Please answer the question or complete the statement as you feel is appropriate. If more space is needed, use the back of the paper. Don't be concerned about sentence structure, etc.--just get the main ideas down. If you have no answer or reaction, just state that.

1. Parents are cruel to children because

2. If the research proposal required that you divulge a confidence between yourself and a client, how would you react?

3. At what age do you find children the most enjoyable and why?

4. The most valuable thing my parents taught me was

5. When an assistant takes action independent of the defined program, the immediate supervisor should

6. At the end of the Pilot Program each program component will be evaluated to determine if it should be expanded, eliminated, or retained. How much decision-making should staff have in this evaluation?

7. People who beat their children should be

8. A child who has been battered should be removed from his parents' care when

9. My relationship with my parents as a child was

10. From your experience what has been the most effective way to discipline a child?

11. If I disagreed with how another staff member was dealing with a child in the Center, I would

12. If I disagreed with another staff member during a meeting with parents, I would

The Retreat and The Return: symptoms and responses to therapeutic treatment of physically abused children. By Steve Stripp.

The purpose of this paper is to examine the behavioral reaction patterns of young children who have suffered physical abuse from their parents. The scope of the discussion covers a general statement of parent-child interaction, definition of a progressive typology, and an examination of data gathered on 45 children during treatment at the Extended Family Center.

The Set-Up: the infant's expression of needs provokes parental abuse.

Human infants are born strongly valuing life. While physically helpless they are emotionally strong. This is evident in the neonates cry with energetic abandon when responding to hunger or external discomfort. They actively oppose being fed when satiated and resist being awakened while fatigue remains. The cry expresses a need requiring parental response. The latter two are a rejection of a parental interpolation of infant needs. These innate responses are the foundations for a healthy self-integrity.

Parents who abuse their children are weak in their valuing of life. They characteristically have incomplete and inaccurate information about themselves (poor self-concept). They have a preponderance of negative feelings toward the

information they do have about themselves (low self esteem). They are afraid to express their need for acceptance (dependency-need frustration). They are suggestible and prone to the plagiarism of the expressed needs of others (ego borrowing). Their weaknesses render these parents so vulnerable emotionally that the very presence of someone who strongly values life can be felt as demeaning and threatening.

Needs are weaknesses. When the body is weak we need food and/or rest. Abusive parents learned early in life to be afraid of their own needs. By minimal or partial satisfaction they perpetuate their weakness. This self-denial from fear is known as being "strong", "realistic", or "adult". The newborn is not afraid to express needs; not fearing weakness makes the infant stronger at valuing life. This is what terrifies the parent. An expression of life strength by the infant is felt as demaning and frightening by the parent. The parent is then provoked to self-defense with anger and denys or interpolates the infants needs. The infant fights this devaluing and wins. Wins because he/she does not accept the parent's response. The sequence continues with the parent losing. It takes life-strength to admit failure and the parent is too weak. The infants innate life force terrifies and enrages the parent; provoking the last resort, physical violence.

The aftermath is hollow triumph. Perplexed, bewildered and frightened some parents admit the abuse and call for help while others, the weaker, deny it and reject aid.

Overwhelmed by trauma the child retreats in shock. When it subsides the child again asserts, again provokes the parent to conquer. In the more severe cases, this pattern continues until the child withdraws from need expression into a protective desensitizing; a chronic shock reaction. Here are the severe reactions: the infants who leave their arms up when placed there; the muffled cry; the limp body; the blank stare. Later it is the preschooler who mimics questions, reverses pronouns; who is obedient to appeasment proportions; who "parents" younger siblings and adults. Here is the child overwhelmed by pain and terror who resigns to perpetual estrangement from his/her own life force.

If the situation is less severe the child is not estranged nor resigned but at war and in chronic battle readiness. Just as the repeated shock reactions generalize to become a behavior style so does the fight reaction. Here are the milder reactions: infants whose angry cries resist all comforting contact, food, and diversion; who sleep from exhaustion; whose slumber is a restless nightmare. These are the toddlers and preschoolers who unprovoked strike out,

spit and bite; who flail in tantrums at mild frustration; who tease another to tears then jeer and laugh. Here is the child who expects his/her surroundings to attack; who is ready to explode first in defense of his/her own life force.

The Retreat: a progressive typology.

Many abused children develop coping reactions consistently different enough to be called styles or types. The more intense the abusive interaction, the more stereotyped the symptoms; the more stylized the coping behavior; the clearer definition of a type. The less intense; the more vague and/or mixed symptoms, styles, and types become.

In the abusive process, described above, there is an increasing intensity in the child's reactions. Four rather distinct levels of intensity are initial conflict, sustained fighting, trauma and shock. Many children stylize or form habit patterns from repeated reactions ending at or emphasizing one of these levels. Four resultant styles are distressed, angry, explosive, and resigned. The last two are more descriptive of dominant coping styles. The first two serve to describe initial symptom clusters of milder cases and repeated testing behaviors of children who improve with treatment.

---

* in the medical sense of progressively worse.

The typology is useful in the prediction of a child's reactions to therapy. Generally the sequence is reversed. The severely abused child, withdrawn and resigned, begins to explode with a variety of negative feelings. Later cools to a periodic display of anger and distress. There is an initial period of two to three months when this sequence reverses after which the children's ability and skill acquisition generally accelerates. This pattern of retreat and return is similar to the descriptions in the literature of infant mourning behavior which occurs at the disappearance of the parents.1

A Typology.

Resigned: a child inhibiting the expression of life force to a bare minimun; a chronic trauma-shock readiness. An infant who attenuates need expression, desensitizes stimului effects, muffles a distress cry, reduces responses to contact, appears listless, dull and blank.

A toddler, in addition to many of the above, who seems unaware of the surroundings, frequently falls over or walks into objects, inhibits expressing pain, seems dissociated from him/herself, ignores his/her own name.

---

1. The retreat sequence is also similiar to the battle fatigued soldier, the disaster victim, and the culture shocked traveler. "There are striking parallels in the way all three respond to overstimulation. First, we find the same evidences of confusion, disorientation, or distortion of reality. Second, there are the same signs of fatigue, anxiety, tenseness, or extreme irritability. Third, in all cases there appears to be a point of no return-- a point at which apathy and emotional withdrawal set in." Check out Alvin Toffler's Future Shock pp. 344-348.

A preschooler may exibit many of the above. Resignation also takes a more active form of self-effacement as repeated gestures to appease others, taking care of others needs, automaton-like obedience, a higher pitched and strained voice. Laughter is rare at all ages and rather grimaced when it does appear.

Explosive: A child at war defending the expression of life force from imminent attack; chronic fight readiness. A phase in therapy for many children. A style for some that appears a few days after entering the theraputic day care scene. In addition to behaviors mentioned earlier (pp. 3-4), there is a variety in the directions the explosive expression takes. The variation is in the outward expressions of the different kinds of negativity the child has suffered. Many children try to get even and to gain command over their own negative emotions by evoking them in others. Children who have suffered chronic distress and the thwarting of need satisfaction actively frustrate others. Those who have suffered more intense frustration are more prone to tantrums and destructive acts. A common style of parental "discipline" is to shame the child's interests or attempts and alternately to frighten the child with impossible performance demands. The shame and fear explode into the unprovoked humiliating and terrorizing of other children.

Angry and Distressed: simply children who get mad or cry more easily than most. Both are more sporatic reactions and children alternate between these more frequently than the previous two styles. An angry type is much better at controlling violence than the explosive and usually gets mad for a reason he/she can express. The distressed type is much less frightened and far more involved than the resigned. Children are more verbal and better learners at this style level.

Typical reactions of these four styles to being hit by another child would be as follows: distressed; whins and backs off, angry; aggressive crying and/or shouting, explosive; screams and/or attacks, resigned; muffled whimper or blank stare.

The intake committee of the Extended Family Center makes an initial judgement on the severity of abuse in an incoming family. In the first year of the program a few preventative cases were accepted. These were families where physical abuse had not yet occured but were judged to be of high risk. The severe and mild judgments were made considering factors like the injuries sustained by the child; the presenting symptoms and histories of the parents.

There is a rough correspondence between the children's styles and their family's case classification. In preventative cases the children were primarily distressed or angry. In mild cases the children were primarily explosive with

accompanying distress and apprehension. In severe cases the children were primarily resigned, sporadically distressed with little initial anger. Significant differences were found on test performance by infants between the severe and mild case classifications.

Data:

Four instruments were used to assess the initial abilities and progress of the children at the Extended Family Center. The Denver Developmental Screening Test was given to all ages. The Bayley Scales of Infant Development were administered to children 2 to 30 months old. The Inventory of Developmental Tasks and the McCarthy Scales of Children's Abilities were given to ages 2½ through 5 years. See the appendix for a discription of the instruments and an analysis of their dependence on verbal responses.

The number of children tested was small. Two criteria were required before any group difference was defined as significant. First the test scores had to be different at the 5% level. If you give the same test to the same child twice in one day or a day apart the score will probably change a little. This first requirement is that there be a 95% chance or better that the child learned something during and/or between the two tests to make for the difference. The second requirement was that the average scores of any two groups of children

had to be at the 1% level. Or that any difference had to have a 99% chance of being due to differences between the two groups. This second check, called a T test, takes the size of the group into account along with the variation of high and low scores within it.

The data is arranged to look at three factors: initial testable abilities; pre to posttest differences; general effects of the months in treatment.

Initial Tests: tables I - IV

These are observations made in the first month of treatment on the average. They show the children to be low in all skill areas tested. Verbal skills are lowest, fine motor (hand-eye coordination) skills are next. The Bayley Mental Scales are primarily a test of these two skills and are lower throughtout than the Motor Scales which test gross muscle coordination. The McCarthy Scales are lower than the IDT results throughout. The IDT is far less dependent on verbal responses or instructions than the McCarthy. (IDT nonverbal tasks = 73% of test, McCarthy = 33%). The Bayleys show a significant difference between the case classifications of mild and severe. The IDTs do not. The Denvers and McCarthys lack enough of one classification or the other to be compared.

TABLE I

INITIAL DENVER TESTS

WHAT THE CHILDREN ARE FAILING AT

BY PERCENT OF TOTAL FAILURES

N = 23	AREAS OF TEST				
AGE NORM	PERSONAL-SOCIAL	FINE MOTOR	LANGUAGE	GROSS MOTOR	TOTAL TASKS FAILED
LOWER 1/4	21.1	24.6	37.7	16.6	114
LOWER 1/10	15.2	32.2	37.3	15.2	59

TABLE II

INITIAL BAYLEY SCALES

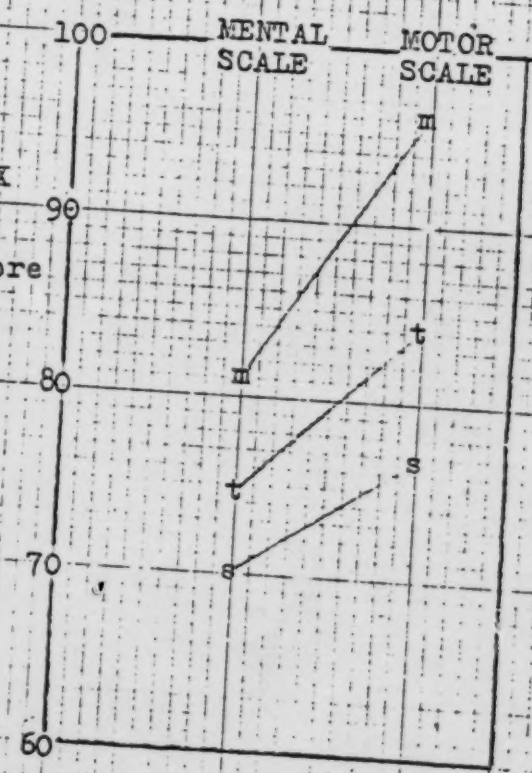
N = 16

m = 10

s = 6

SCALE INDEX

100 = an average score



s = severe

m = mild

t = total for both groups

Sig: severe:mild

	Mental	Motor
SE_m	× 2.09	× 3.65
p	< .036	< .003
t =	5.90	8.97
p	< .001	< .001

TABLE III

INITIAL I D T

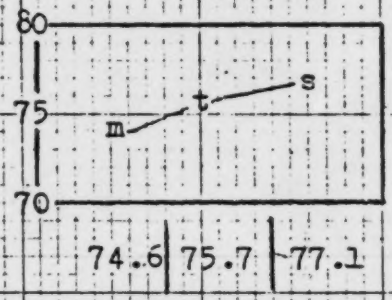
BY TOTAL TEST SCORE

N = 20

s = 9 m = 11

SCALE INDEX

100 = an average score



s = severe
m = mild
t = total of both groups

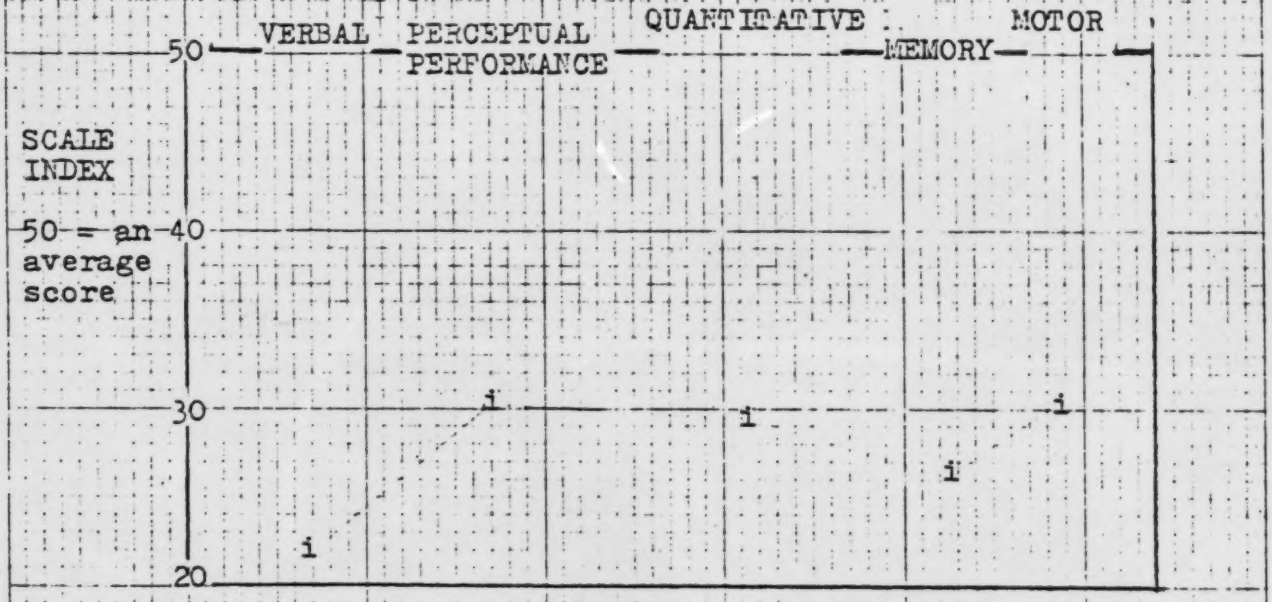
no Sig. dif.
s:m

TABLE IV

INITIAL McCARTHY SCALES

BY AREA OF TEST

N = 9



GENERAL COGNITIVE (V+PP+Q) = 50.4
an average GC = 100

Pre to Posttest: tables V - X

Significant gains on all four instruments: The Denvers show significantly fewer task failed below 25% of the age norm. Language tasks showed the greatest improvement and had fewer failures at the posttest than the other areas: tables V and VI.

The Bayleys have significant gains on the Motor Scales. The Mental Scales show improvement, but the test score differences were 3.5% above the 5% level: table VII. The six infants who scored below 80 on either scale made significant gains: table VIII.

I. D. T. scores went from "borderline" to "average" levels with a significant increase of 21% over the pre-test. The McCarthy scores for the composite General Cognative scale were significantly increased: they moved from "mentally retarded" to "borderline" levels. Verbal skill gains were high, but the test score differences missed the 5% criterion by 1%. The average time between pre and posttest was the shortest for the McCarthy scales.

TABLE V

DENVER TESTS PRE TO POST

BY NUMBER OF TASKS FAILED BELOW

25% OF AGE NORM

AREAS OF TEST

	PERSONAL SOCIAL	FINE MOTOR	LANGUAGE	GROSS MOTOR	TOTAL TASKS FAILED
PRE-TEST	15	13	18	9	55
POSTTEST	9	8	4	7	28

$t = 4.79$

$p < .001$

TABLE VI

DENVER TESTS PRE TO POST

BY NUMBER OF TASKS FAILED BELOW

10% OF AGE NORM

"TECHNICAL FAILURES"

AREAS OF TEST

	PERSONAL-SOCIAL	FINE MOTOR	LANGUAGE	GROSS MOTOR	TOTAL TASKS FAILED
PRE-TEST	7	9	10	4	30
POSTTEST	1	3	0	4	8

for both Denver tables:

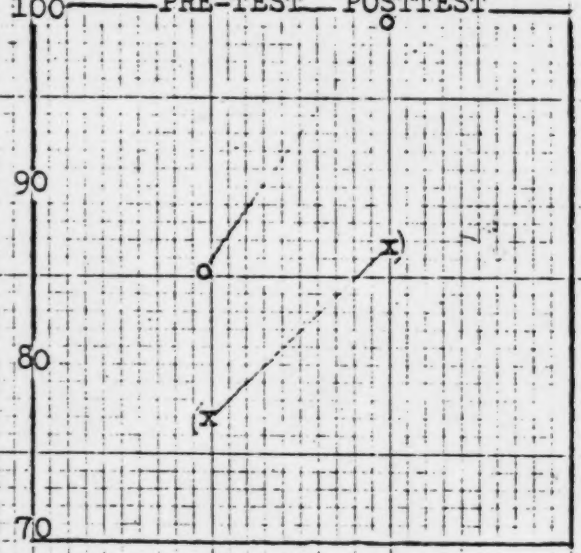
N = 10 Time in center prior to pre-test = $\bar{X}$ = 1 month.

Average number of months between pre and post = 6.3

TABLE VII

BAYLEY SCALES PRE TO POST

N = 10



o = motor scale

x = mental scale

2.1 month = average time in center prior to pre-test

9.8 months = average time between pre and post

Sig: motor

SE_m * 2.32

$p < .025$

$t = 7.89$

$p < .001$

mental

(SE_m × 1.35)

($p < .085$)

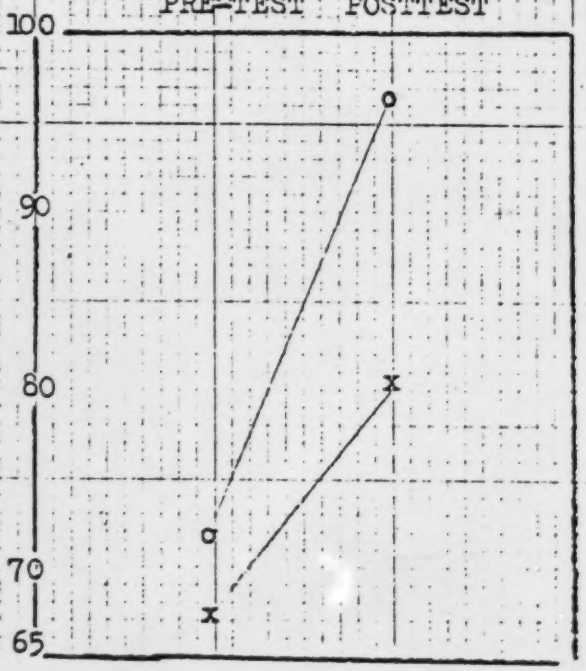
$t = 5.548$

$p < .001$

TABLE VIII

BAYLEY SCALES PRE TO POST

SIX INFANTS BELOW 80 ON PRE



motor Sig;

SE_m × 5.07

$p < .001$

$t = 7.17$

$p < .001$

mental Sig:

SE_m × 2.42

$p < .016$

$t = 4.0$

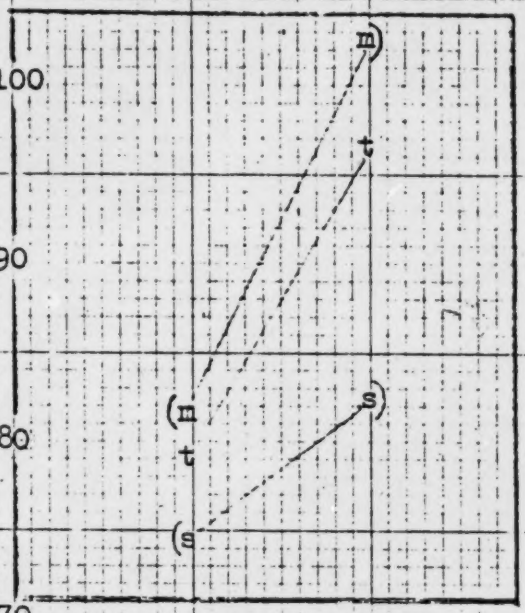
$p < .01$

TABLE IX

N = 14

I D T SCORES PRE TO POST

BY TOTAL TEST SCORE



t = total group
m = mild
s = severe

SCALE INDEX

100 = an average score

X months in center prior to pre = 3.3

X months between tests = 8.3

Note: average time between pre and post

m = 10.4 months

s = 4 months

Sig. Dif. pre:post

5.39 SE_m

p .001

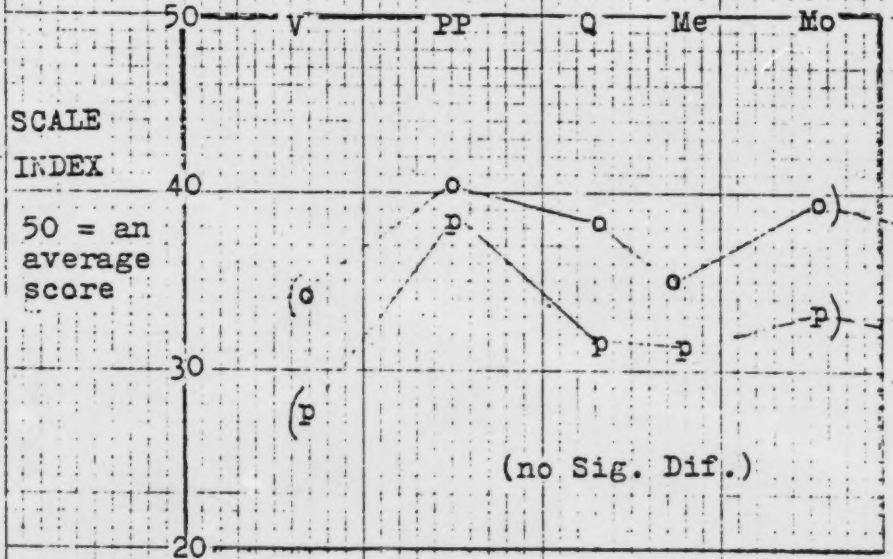
t = 10.18

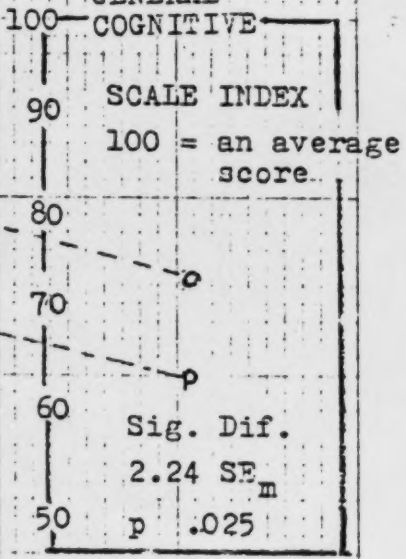
p .001

TABLE X

McCARTHY SCALES PRE TO POST

BY AREA OF TEST





p = pre-test

o = posttest

average time in center prior to pre = 6.9 months

average time between pre and post = 5.6 months

Sig. Dif. G C: t = 3.80, p .002.

Months in Treatment: tables XI - XIV

These tables are a look at all the observations in the same time period during treatment. Four periods are used: 0 - 1 month, 2 - 4 months, 5 - 11 months, 12 months and over. The average months in treatment for each period is stated on the tables. The Bayleys do not show a significant difference. The infants vary significantly in their scores between severe and mild. This difference is greater than that between the observation periods. The first two periods are significantly different from the last two for the preschoolers.

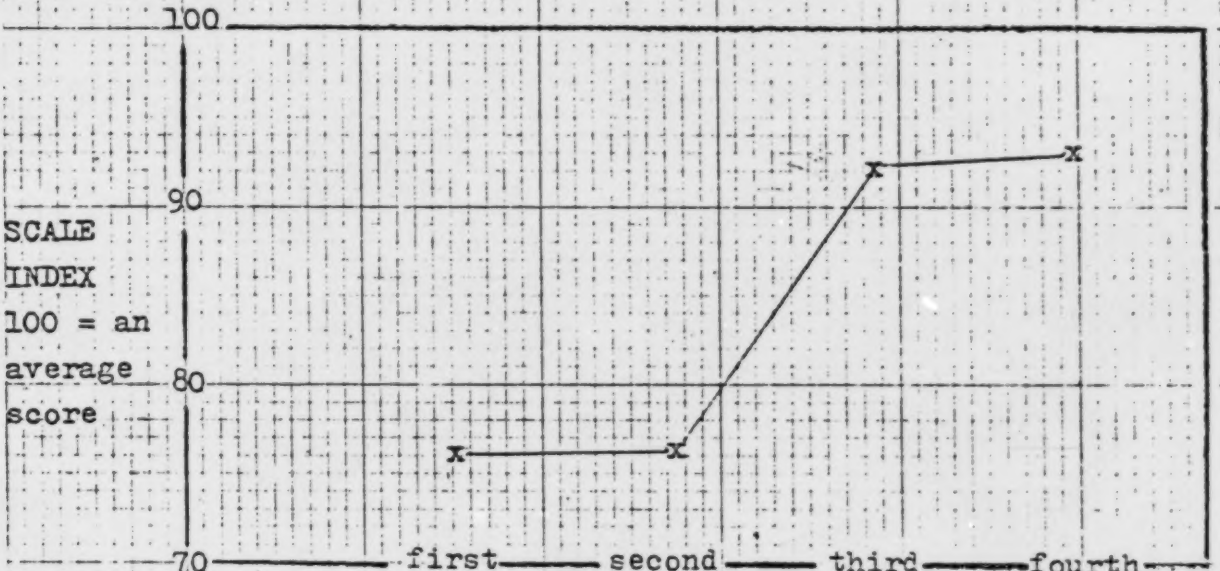
Both the infant's and older children's tests show little change during the first three or four months. This gives some support to the notion mentioned eariler that there is a reversal or return period in the beginning of therapy. This is the period children need to recontact and/or defuse before skill development can grow aided by positive social interaction.

After the initial period there is an acceleration of scores; marked for preschoolers, mild for infants. This adds further support to the return period concept. It is the cooling out time when children relax somewhat with increased trust and self-confidence. They are more open to expressing old skills and acquiring new ones.

TABLE XI

MONTHS IN TREATMENT: I D T

ALL I D T SCORES LISTED BY THE MONTH OF OBSERVATION



	first	second	third	fourth
RANGE	0-1 mo.	2-4 mo.	5-11 mo.	12 + mo.
AVERAGE	3 weeks	2.6 mo	6.8 mo.	14.8 mo.
OBSERVATION N	N = 16	N = 7	N = 9	N = 12

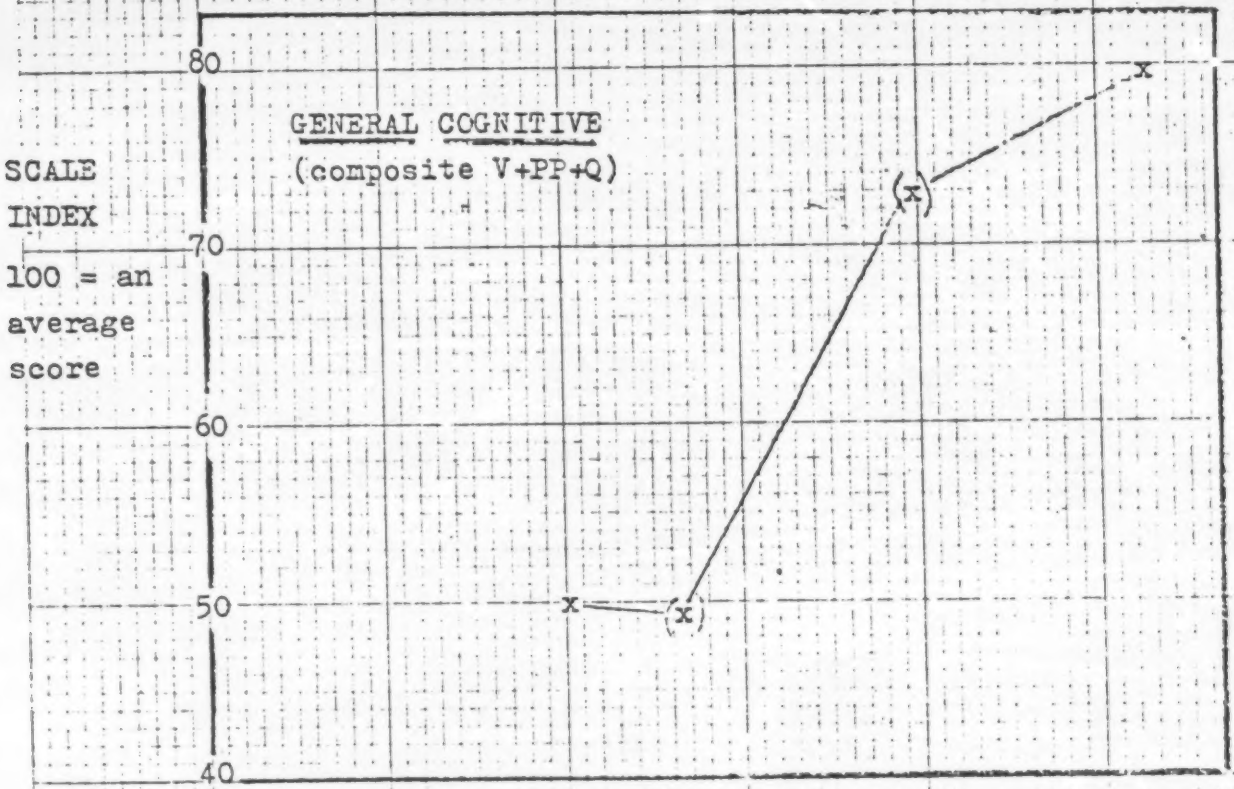
MONTHS IN TREATMENT

Sig. Dif. by time period	first:third	first:fourth	second:third	second:fourth
	5.2 SE_m	5.59 SE_m	5.23 SE_m	5.62 SE_m
	$p < .001$	$p < .001$	$p < .001$	$p < .001$
	$t = 3.71$	$t = 11.4$	$t = 7.44$	$t = 9.2$
	$p < .002$	$p < .001$	$p < .001$	$p < .001$

TABLE XII

MONTHS IN TREATMENT: McCARTHY SCALES

ALL McCARTHY SCORES FOR GENERAL COGNITIVE
LISTED BY MONTH OF OBSERVATION



RANGE	0–1.5	2–4 mo.	5–11 mo.	12 + mo.
AVERAGE	1 mo.	3.2 mo.	8.1 mo.	15.6 mo.
OBSERVATION N	8	(3)	(4)	8
PERIOD	FIRST	SECOND	THIRD	FOURTH

Sig. Dif. first and fourth (only)

$7.17\ SE_m$

$p < .001$

$t < 5$

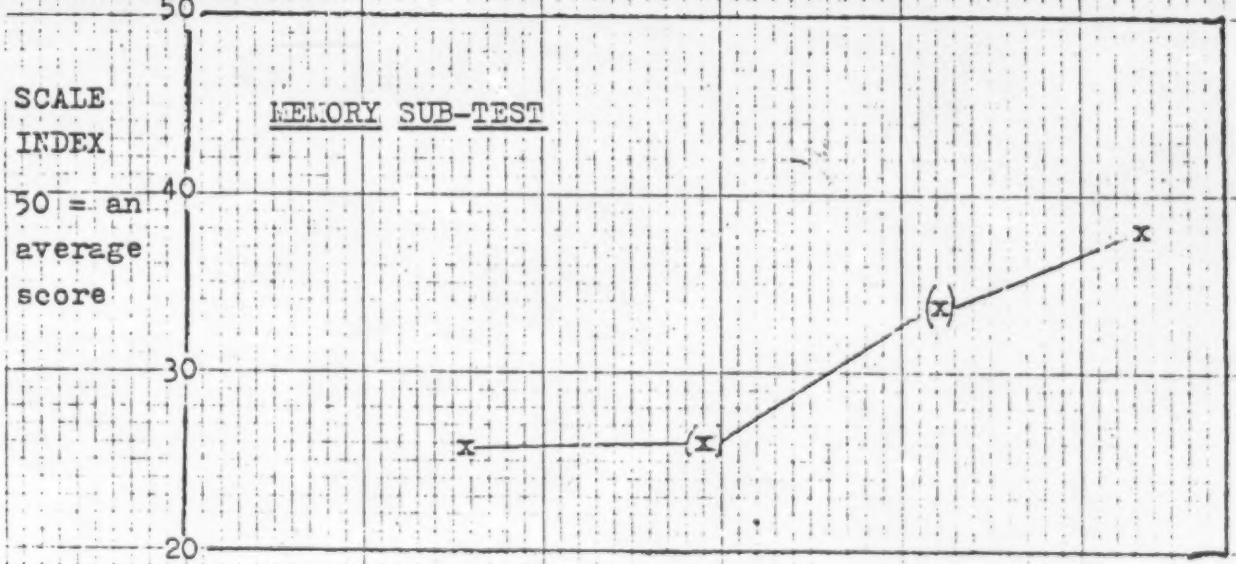
$p < .01$

TABLE XIII

MONTHS IN TREATMENT: McCARTHY SCALES

ALL McCARTHY SCORES FOR MEMORY SUB-TEST

LISTED BY MONTH OF OBSERVATION



RANGE	0-1.5 mo.	2-4 mo.	5-11 mo.	12 + mo.
AVERAGE	1 mo.	3.2 mo.	8.1 mo.	15.6 mo.
OBSERVATION N	8	(3)	(4)	8
PERIOD	FIRST	SECOND	THIRD	FOURTH

SIG DIF. first and fourth (only)

2.62 SE_m

$p < .01$

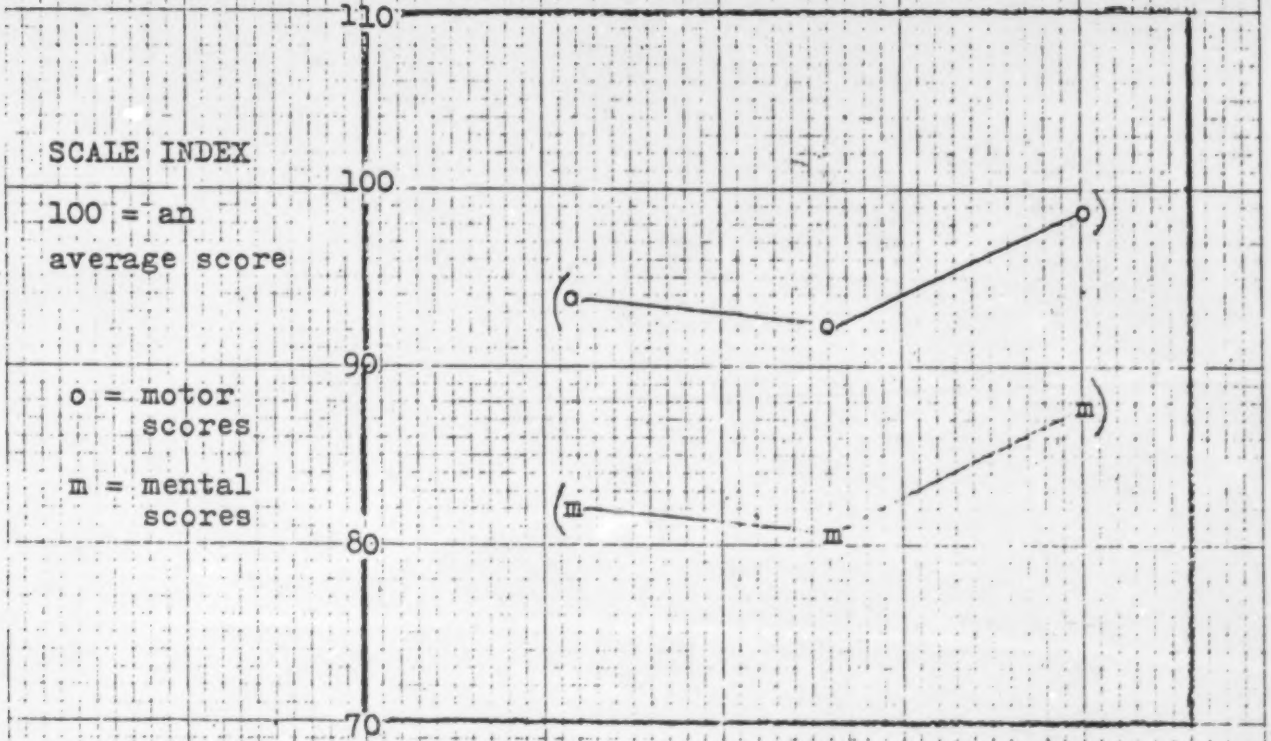
$t < 4.5$

$p < .01$

TABLE XIV

MONTHS IN TREATMENT: BAYLEY SCALES

ALL BAYLEY SCORES LISTED BY THE MONTH OF OBSERVATION



RANGE	0–1.5 mo.	2–4 mo.	5–11 mo.
AVERAGE	2 weeks	3 mo.	9 mo.
OBSERVATION N	12	5	9
PERIOD	FIRST	SECOND	THIRD

(No Sig. Dif.)

Appendix

Description of Diagnostic Instruments

It is important to note here that some general understanding of pre-school and infant tests as they relate to later test used to measure the verbal and performance skill areas is necessary before an accurate interpertation of the findings is possible.

Unless supplemented by other clinical data; specifically observations and personal histories of the infants, there is virtually no 'predictive validity' between infant tests and subsequent tests of general intelligence. Pre-school tests have moderate validity in prediciting subequent performance on intelligence tests.

The whole area of 'intelligence' testing is bound up with important issues of differing language, dialect, and cultural backgrounds. Generally a test which utilizes a majority of verbal skill tasks will be more cultural specific than one which utilizes nonverbal performance skill tasks (reasoning through the use of designs, memory of symbol arrangements, etc:). There is no test of innate intellectual capacity as yet developed.

The four instruments used with the children at EFC differ in the number of verbal and nonverbal performance tasks each presents to a child. The table below summarizes the task distribution of the four:

The Number of Tasks

Test Name	verbal response	verbal inst.	nonverbal	total
Denver	21 (20%)	1 (1%)	83 (79%)	105
Bayley	14 (6%)	5 (2%)	225 (92%)	244
I D T	16 (27%)		44 (73%)	60
McCarthy	91 (60%)	10 (7%)	52 (33%)	153

(Nonverbal includes those tasks where the instructions can be and in cases have been given by physical demonstration. Verbal inst. means the task must rely on verbal instructions but not on verbal response: "draw a person")

A. The Denver Developmental Screening Test.

This one is a favorite in most hospitals. Its fairly easy to give and doesn't take a long time to learn how. It provides a rough sketch of a child's abilities and can indicate a need for further testing. It has four areas: personal-social, fine motor-adaptive, language, and gross motor. The number of tasks on each are: 23, 30, 21, and 31. It covers an age range from one month to six years.

B. The Bayley Scales of Infant Development. (1969)
These two scales are fairly recent revisions of the California First-Year Mental Scale (1933 - for you test buffs). They are rather complexed to learn and administer. The 244 tasks are divided into two scales. There are 81 on the Motor Scale which are mainly gross motor tasks and 163 on the Mental Scale which are a collection of sensory responsiveness, fine motor, perceptual, and language tasks. The age range is from one to thirty months.

C. The Inventory of Developmental Tasks (IDT). ('68)
This test was developed at Santa Clara Unified School District with the aim to have teachers use it as an aid in individualizing instruction. It displays the results visually on a gird sheet, similar to the Denver, so that a child's strong and weak areas are apparent. The results of the IDT and Denver have been totaled into a single scores for comparison with the other two measures. The IDT is made up of eight areas arranged in levels of complexity. There are 11 gross motor tasks, 10 fine motor, 9 visual perception, 8 visual memory, 7 auditory perception, 6 auditory memory, 5 language, 4 conceptual (3 French hens...) The age range is about 3 to 6½ years old.

D. The McCarthy Scales of Children' Abilities. ('70)
It was developed by "the intuitive and functional considerations" of its author Dorothea McCarthy on the basis of her "extensive teaching and clinical experience in developmental psychology and her many years of training and supervising test examiners."[1] Generally it held up under factor analysis (a statistical test of the test). EFC is using this test and the Bayley in the program evaluation with another treatment center serving the parents only. The McCarthy is made up of 18 subtests which are grouped and overlaped at points into six scales. The scales are called; verbal, perceptual-performance, quantitative, general cognitive, memory and motor. The age range suggested is 2½ to 8½ years old.

---

1. from the Manual of the McCarthy Scales of Children's Abilities, Dorothea McCarthy, The Psychological Corporation, N.Y, N.Y. p. 2.

Appendix 4

Report of EFC Closure

Published in S.F. Child Abuse Council Newsletter

September 1976

WHATEVER HAPPENED TO THE EXTENDED FAMILY CENTER? by Norma Campbell, former chief social worker, EFC.

It closed. In spite of universal praise and support for the program; in spite of the staff's monumental efforts to keep the program functioning, the Extended Family Center was not able to secure funds to remain open. Below is a summary of the events leading to the Center's demise and my perspective on "why" it happened.

When I joined the Center's staff in March 1976 it was in crisis, partly because of tensions between EFC and its umbrella organization, partly because of the failure of the Federal government to guarantee support for child care slots. The crisis was diverting substantial staff/parent time and energy, but all were hopeful that the financial (and other) problems would be resolved.

But in May 1976 two major blows were dealt the Center. First, the U.S. Senate failed to override President Ford's veto of the federal child care bill, leaving many child care centers, including EFC, without subsidized slots. Secondly, conflicts between the Center and its umbrella agency could not be resolved, and establishment of EFC as an independent agency became imperative. The Center would no longer have the administrative and financial support of any outside agency after July 1, 1976. With a guaranteed budget of only $60,000 for FY 76-77 (the total budget for FY 75-76 was $160,000) the Center had to figure out a way to remain open and begin a search for more funds.

We did it. On July 1, 1976, we began a severely modified program relying on only 5 paid staff and staff and non-staff volunteers. We used community resources to supplement our budget program. We continued to provide comprehensive services to over 20 families, while at the same time trying to write grant proposals and establish EFC as a non-profit corporation.

Our hopes rested primarily on monies from a State Child Care Bill. In September 1976 we learned that the Center was not granted funds under the Bill. The summer had taken its toll on the energy and morale (not to mention finances) of staff and parents and we closed.

Responsibility for the Center's demise does not lie in any one corner, but these factors seem to be important:

1) There is simply not enough money available for social programs. The State child care monies on which we were depending totaled only $10 million. Over $35 million in requests were made for Center-based day care alone.

2) What money is available for programs like EFC does not filter down to proven community programs. The federal Office of Child Development has had a policy of funding demonstration programs only. EFC was a demonstration program for 3 years. After the OCD grant ended, the Center experienced the not atypical difficulty of being stranded by the federal government (financially and in terms of technical assistance). There is federal Title XX money available for service (rather than demonstration) projects, in child abuse and neglect, but in California it goes exclusively to Protective Services.

3) Child Abuse and Neglect is everyone's stepchild. Mental Health Services don't accept it as theirs. The State Department of Education has no special provision for services to children from abusive and neglectful families. These children are not necessarily eligible for services through the expanding Developmental Disabilities program. The Department of Social Services claims these families, but makes no provision for the kind of non-traditional services, such as those offered by EFC.

4) Agencies involved in child abuse and neglect have dealt with common problems competitively rather than cooperatively. This year the Antonovich Bill allocated $100,000 given over a 2-year period to two treatment centers, one in Southern California, one in Northern California. A paltry sum to begin with, interested projects were forced to vie for the money with no collective or overall assessment of the total needs of the State or these programs. It appears that the money was awarded to programs with the greatest political clout.

5) Verbal support was not translated into action. There were numerous individuals and agencies who did what was in their power to do to help. Unfortunately, there were many who were in a position to offer significant technical assistance and energy, who expressed concern but did not act until the eve of the Center's closing in September. These ranged from an attorney who consistently misrepresented the progress

of incorporation process, to professionals whose job is to provide assistance to programs like EFC. These latter were aware of EFC's crisis from April on, but their offers of administrative, legal, and financial assistance came in September.

WHAT HAS HAPPENED TO THE STAFF AND PARENTS OF EFC?

Several staff have moved on, others continue to do Center-related work, finishing old obligations, maintaining contact with parents, or working towards possible reopening of the program. The parents and children were referred to other agencies or day care centers where needed. Several, who were ready for graduation, are doing well. Others are receiving help from other agencies. Others are falling through the cracks because traditional agencies cannot provide the comprehensive services EFC offered. There are also those families who would be referred to EFC if it were open. Instead, they take their chances in the maze of traditional agencies.

If any good is to come from the Center's closing, it must be in alerting the community of people and agencies involved with abuse and neglect to the problems of maintaining a viable and innovative community program. The Extended Family Center will not be quickly or easily replaced. If it is, look carefully at EFC's history, and don't let it happen again.